South Western Ambulance Service NHS
NHS Foundation Trust

Electronic Patient Clinical Record

Configuration User Guide

Version 1.0 - January 2015

responsive committed effective

Contents

1. Introduction

1.1 In line with a government initiative to develop a paper free NHS, the Trust, has been working on the development of an electronic Patient Clinical Record (ePCR) system fit for a modern 21st century ambulance service. The ePCR has been created in partnership with Ortivus who is a leading supplier of mobile solutions for modern emergency medical care. The solution aims to eradicate paper based data collection, enhance the clinical decision making process and support the provision of the Right Care in the Right Place at the Right Time.

1.2 The system in essence did not exist prior to contract signature and has therefore been designed from the ground up by the small but very dedicated project team in SWASFT. Using a structured model of examination and assessment the software is configured so as to take the clinician through a structured process, capturing any and all clinical interventions and where possible and appropriate incorporating validated assessment tools to enhance the clinical decision making process. This in turn allows the clinician to use the device to support their clinical assessment and ensure that patients are conveyed or signposted to the most appropriate service.

1.3 The product offers full N3 connectivity at a Clinical Workstation, connecting the individual end user device via the 3G network. This allows the acute trust and other clinical partners to view the appropriate record and provide early indication of potential patients with regards levels of acuity and likely interventions. The device also provides for full NHS Spine connectivity and will therefore support both the Summary Care Record and Enhanced Summary Care Record.

1.4 The solution communicates to a Vital Signs monitoring equipment also provided by Ortivius. This Mobimed system communicates via Bluetooth to the ePCR, auto populating biometric data, making the transition of such data quickly available to the acute trust via the N3 network and Clinical Workstation. This workstation is alertable and incorporates an instant messaging functionality to allow for rapid review of ECG and supportive communication between hospital and pre-hospital clinician.

1.5 The capture and controlled transmission of patient data is available in the form of highly configurable output forms. This can be created and auto populated from data already entered, to enable Falls Referrals, TIA Clinic Referrals, Safeguarding Referrals and other suitable clinical outputs which further enhance the patient outcome and patient experience.

1.6 The device also provides a platform for other uses supportive of the clinical environment. The device incorporates a web browser, enabling the clinician to view a selection of approved websites such as Toxbase, Athens and NICE. The device also holds a number of hard file documents, such as JRCALC, other national and local Clinical Guidelines, Patient Group Directions and Operational Instructions.

1.7 The system can and will also enable access via web links to the Directory of Services. Crews are often unaware of the options available to them to enhance the appropriateness of conveyance and this will greatly enhance the ability of SWASFT to build on its Right Care agenda, increasing the appropriateness of conveyance and decreasing the numbers inappropriately conveyed to the emergency departments.

1.8 Clearly the benefits the system brings relate to enhancing the patient experience, supporting the decision making process and opening up real opportunities for the transmission of data. But equally important is the data that will be captured by SWASFT in relation to its operations. Such data will enable real opportunities in terms of research in to pre hospital care, research that up to this point has been incredibly onerous and reliant on review of paper based systems.

2. Data Entry

2.1 The system is designed with a large number of data entry fields, these take the form of simple boxes to click which indicate a positive, or negative (Yes and No boxes), drop down checklists, decision support tools and free text fields.

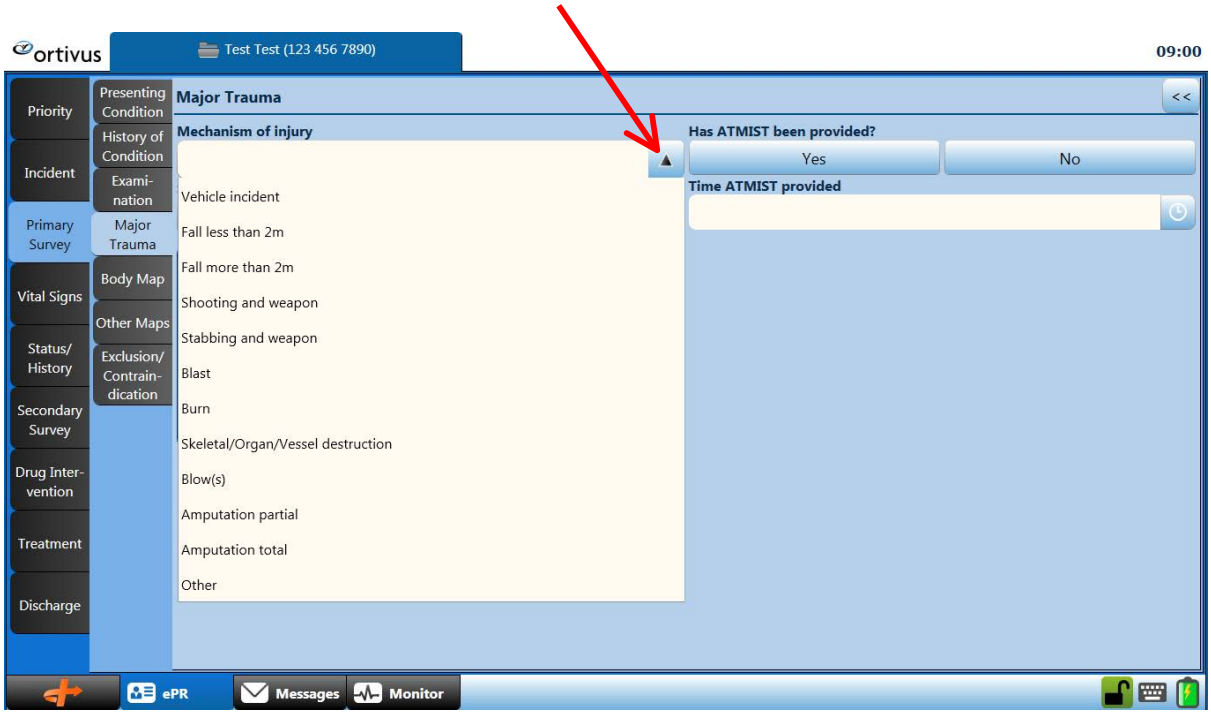
2.2 Free text boxes expand as data is entered, they should be used to provide supporting information for the other forms of data entry and to provide a narrative or to provide information which does cannot easily be entered as a single button. Boxes and drop down selections assist the clinician, guide decision making where appropriate and also ensure that the information that may be required by the Trust for clinical audit, research and for external agencies such as the Police and Coroner is available.

2.3 Only data relevant to the patient's assessment or examination need be completed, whilst multiple data fields exist not everyone is relevant to each and every patient interaction. The system is designed to cover all patient groups, if it is not relevant to the patient in front of you, don't fill it in.

2.4 All data you may wish to enter has a corresponding field, get used to the system and learn where the data entry points are. As experience grows the use of the system will support greater clinical record keeping and enable you to make use of the wider functionality.

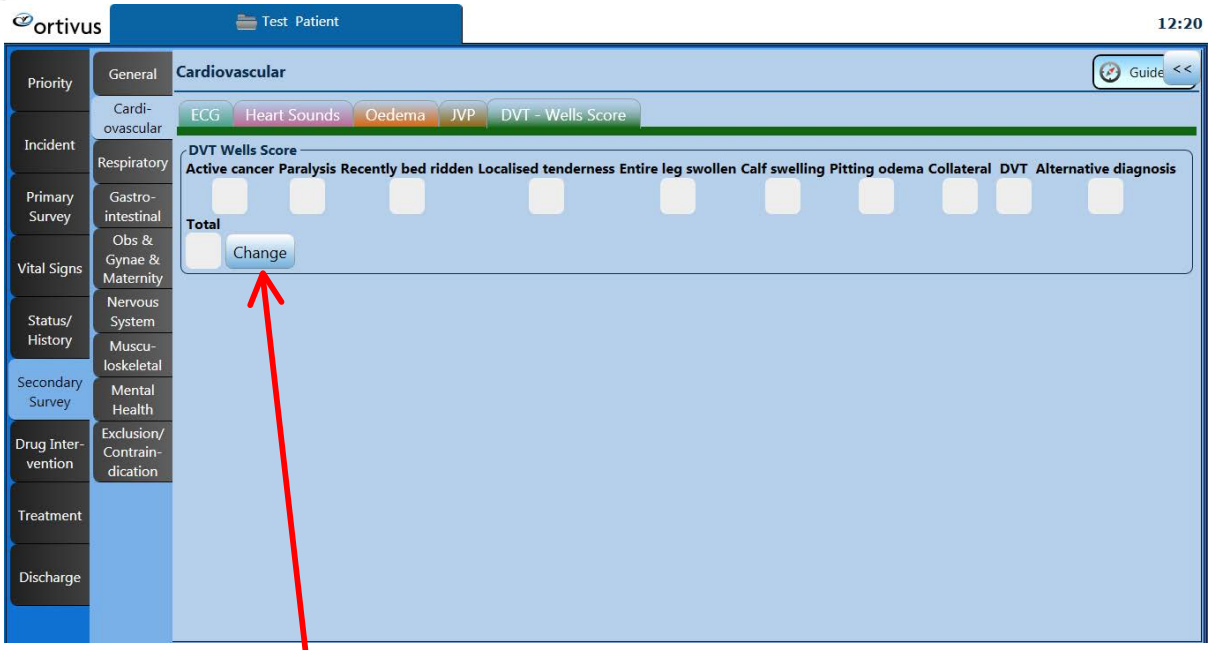
2.5 Various mechanisms are used to assist the clinician in the provision of **Data Entry**. Many fields are captured using simple **Yes**, **No** type buttons. This is supportive of the clinician and enables quick data entry; it is also hugely beneficial in terms of data analysis. Free text on paper records is notoriously difficult to analyse, but data fields with pre-defined definition can be used with great effect to appreciate trends over time and assist the trust in researching pre-hospital care to improve patient outcomes.

2.6 Drop Down lists are also provided to support the clinical record keeping where the answers to a question may be variable. The presence of a drop down list is indicated by the **drop down black arrow**.

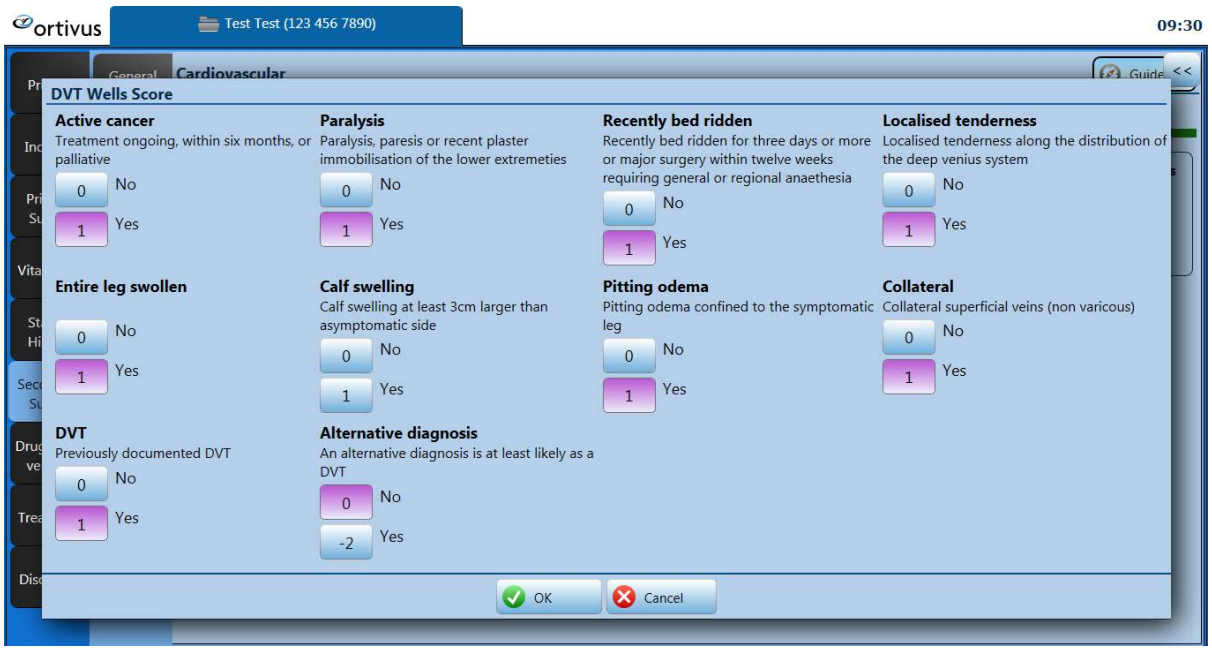


2.7 A number of clinical decision tools are available within the configuration, these utilise Checklists and scoring systems to aid the clinicians decision making. The Wells Score for DVT (Deep Vein Thrombosis) is a nationally validated tool which assists in determining the risk of a DVT being present.

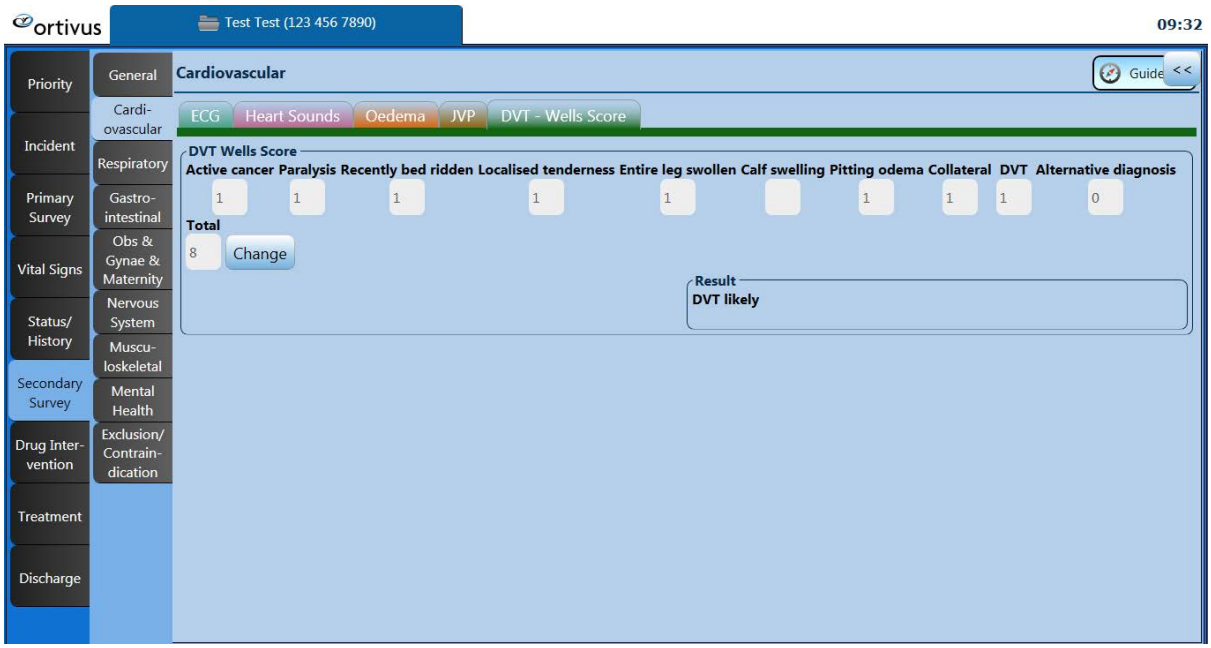
The tool is accessed via the **Change** button as below



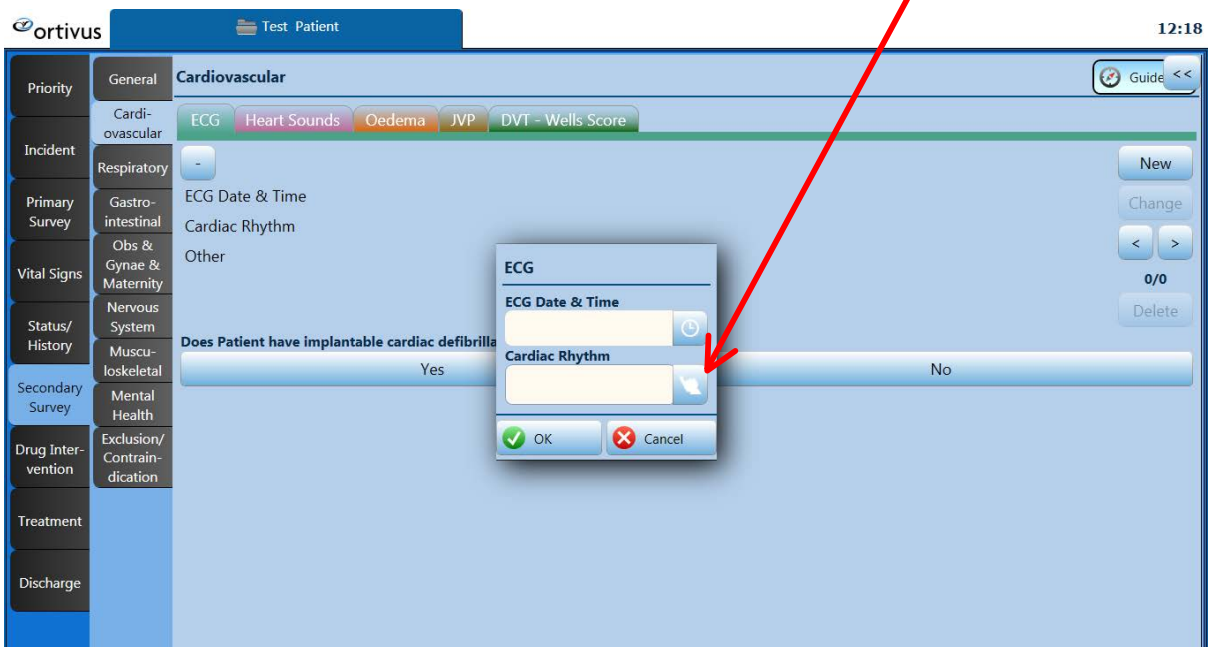
2.8 Once the **Change** button is clicked the **Checklist** opens. The clinician is directed to ask specific questions or undertake specific assessments. Each requires the clinician to input the result and once all have been completed to click the **Ok** button.



2.9 An outcome is then provided either in terms of **the relevant risk** or with specific guidance, as below.



2.10 Within some screens as in the **ECG** screen within Cardiovascular which allows the clinician to document the patients ECG, a **white finger symbol** is used to highlight the availability of, and open a drop down list of multi select options.

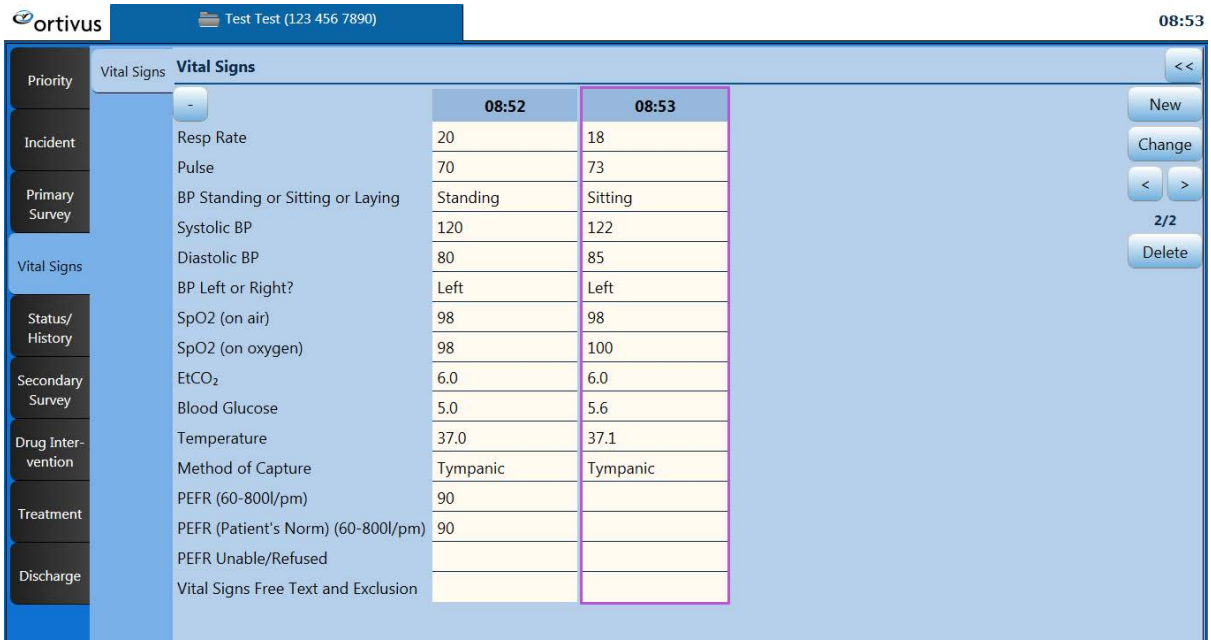


2.11 Some patient assessments may be required to be undertaken on more than one occasion, the patients vital signs for example may be entered on numerous occasions during the patient contact to capture trends, or show improvement or deterioration. Multiple assessments fields are available via the **New** button which open up the data entry points for each new set of data.

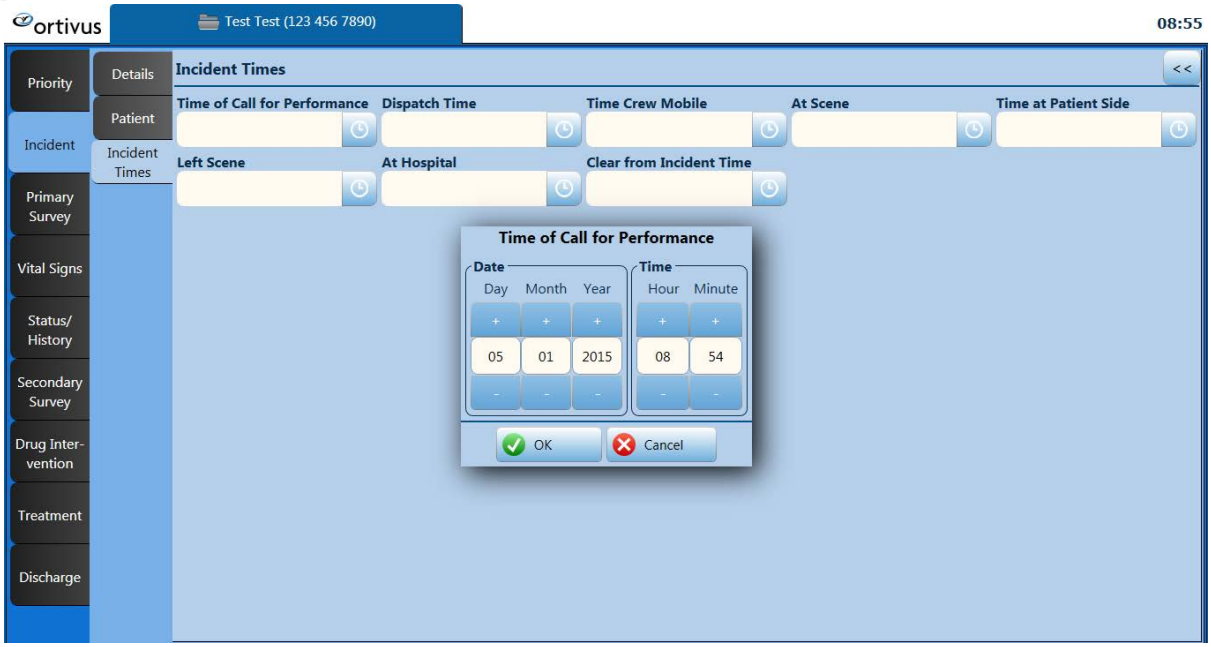
To enter an additional data set, the clinician simply clicks on New to open up a new assessment field.

Additionally once this data has been entered it can be changed, or deleted as required using the **Change** and **Delete** buttons as below.

2.12 The clinician clicks on the set of observations or data set requiring change/deletion the set of data, in this case observations will be outlined in purple. The clinician can then click on **Change** or **Delete** as appropriate. If change is selected the set of observations will appear for adjustment as required.

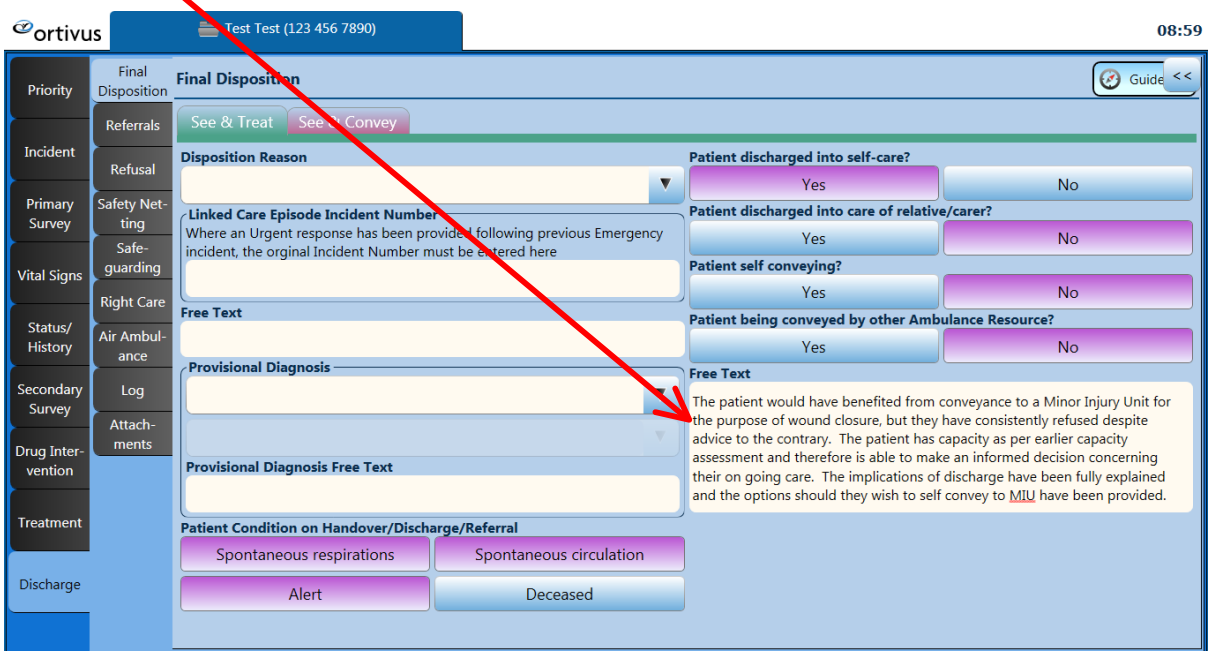


2.13 Time Fields are identified  by the clock symbol. If the clinician clicks on any blank the current time and or date will be automatically inputted. Should the clinician by retrospectively entering data, they can enter the correct time of assessment by clicking on the clock symbol and adjusting the subsequent date and time can then be adjusted upwards or downwards as appropriate, by using the + or – buttons.



2.14 Whilst as mentioned earlier, drop down boxes and structured data entry is used to assist the clinician, support decision making and enhance the quality of data capture. However, some assessments or patient information cannot be adequately captured within a structured format and require the use of **Free Text** format.

Free text in particular can be used to evidence decision making, which supports any use of the individual clinical record for the purpose of, complaints, concerns, Serious Incidents, trauma review, Coroners Court etc.



3. Main Menu page

3.1 The main menu page is opened automatically as the End User Device (EUD) is turned on. This page provides access to the central functions of the device for both the electronic Patient Clinical Record (ePCR) and Vital Signs Monitoring (VSM).

3.2 The **Ortivus Logo** at the top left of the screen can be used to access information relating to the device, by clicking on the **Logo** you will see details relating to the version of software, unit details, license number and current configuration software. This information may be requested by the Logistics team when reporting a fault.

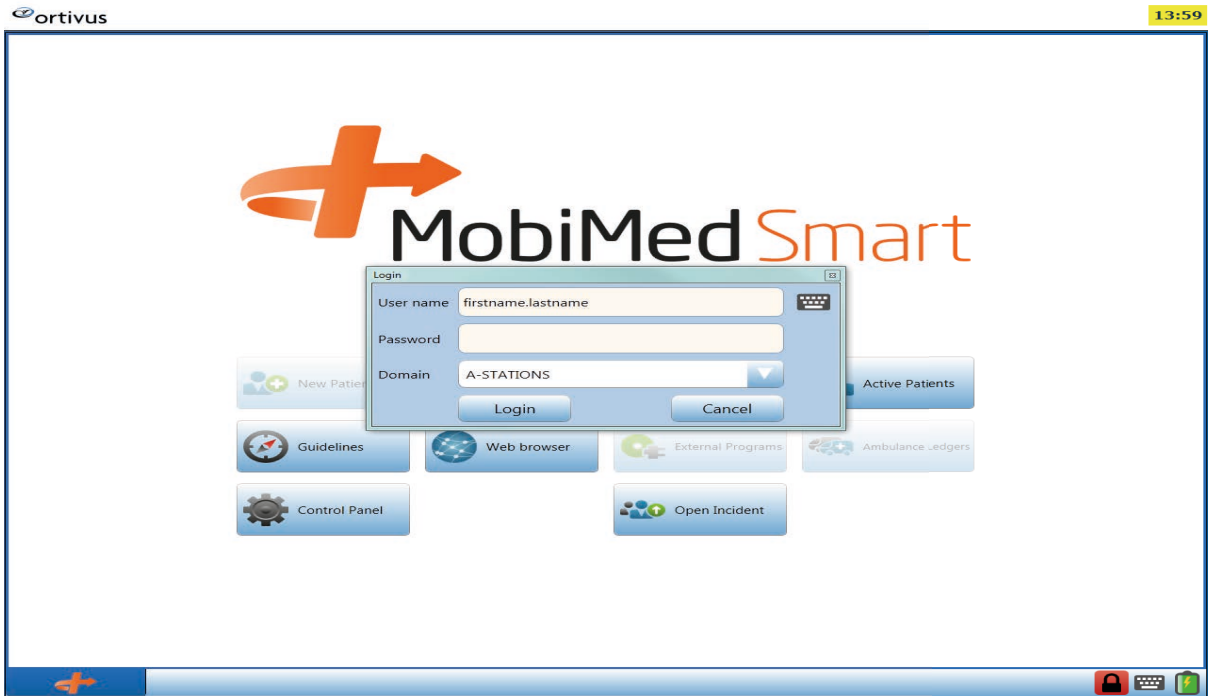
3.3 The bottom right hand of the screen shows information relating to current battery status, connecting to **VSM**, access to on screen keyboard and current log on status. By clicking on the green battery symbol you will see a display showing current **Battery** life. The VSM monitoring device icon when present means that the ePCR is not currently paired with a VSM. In the image above no VSM icon is present, this means the ePCR is currently paired to a VSM monitoring device.

3.4 The **Padlock** icon shows whether the user is logged on to the system. Red denotes not logged on but in signal, orange denotes, not logged on, but out of signal so this cannot be achieved and green denotes logged on.

3.5 To log on the user either clicks on the padlock icon or on the login button on the main menu. A **Log in** box will appear so the user can enter their normal trust user name and password.

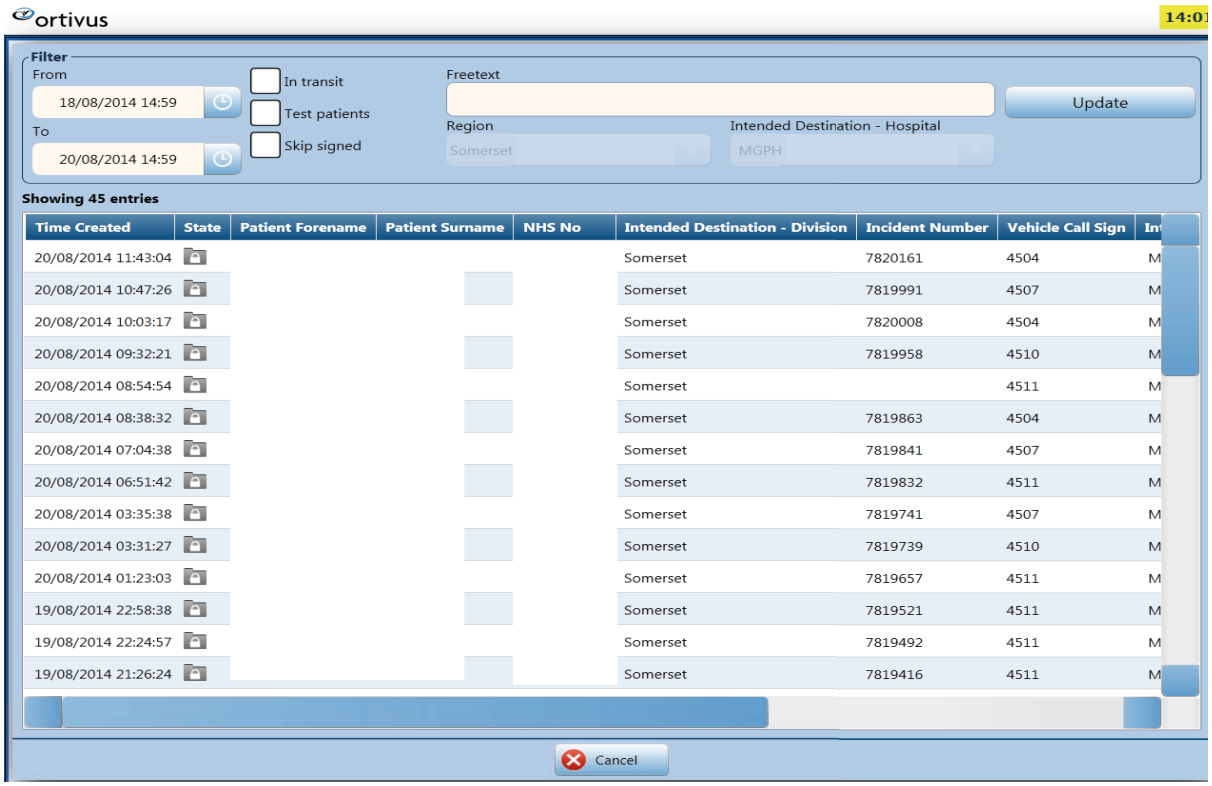
3.6 If you have difficulty logging on, it may be that your **Password** has expired, please ensure that you keep your password up to date, when accessing your

emails or using a trust computer, you will receive reminders in advance of any password change, so please ensure you change it to prevent difficulties accessing the ePCR.

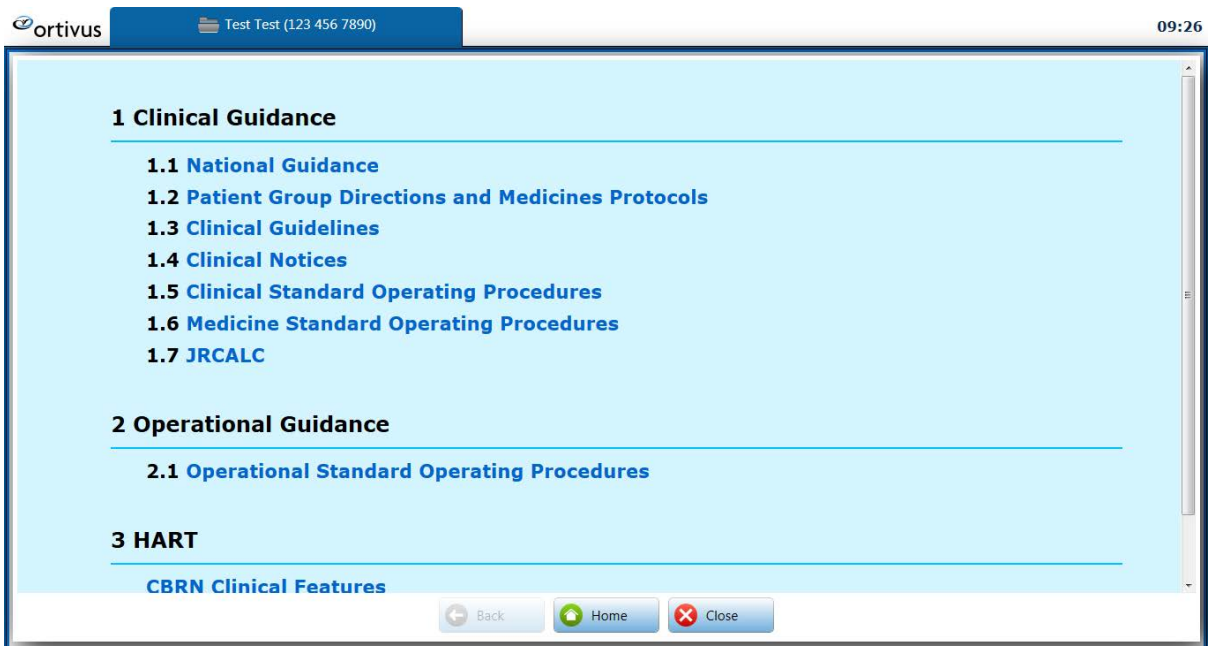


3.7 **Open Patient**, this function enables the user to look at closed but not signed records. This will for example allow a crew to pick up a record started by an RRV that relates to a patient they are subsequently being asked to convey.

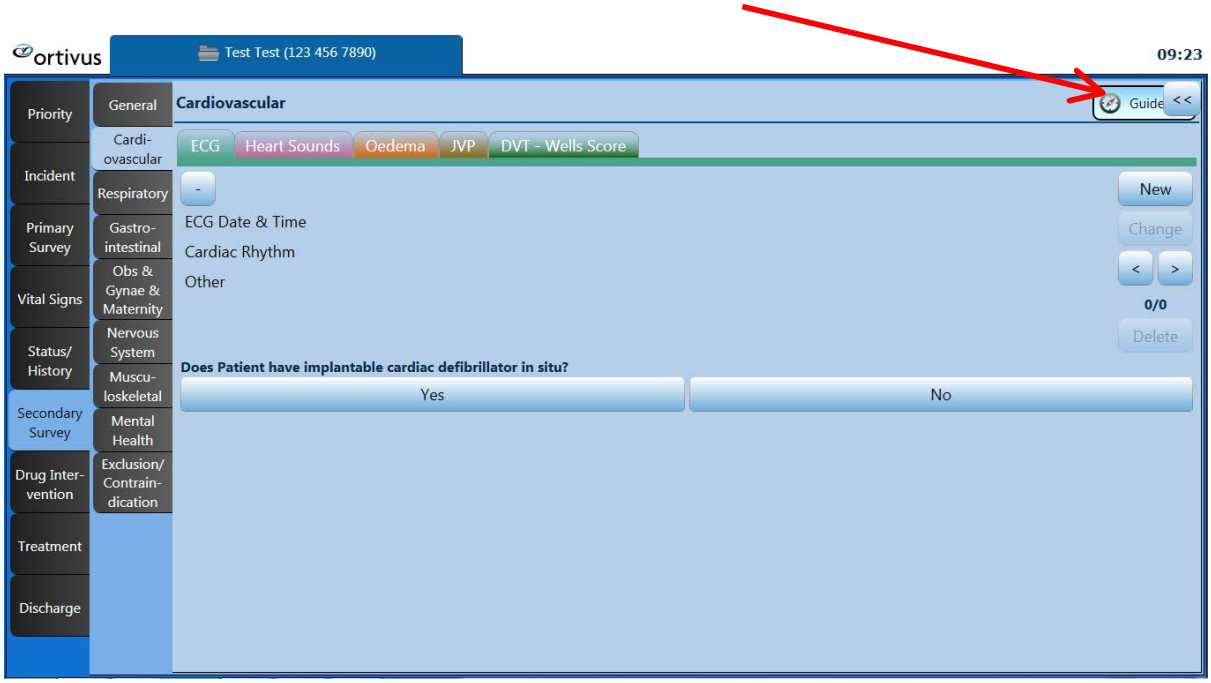
3.8 On clicking **Open Patient**, a list of incidents will appear which can then be selected.



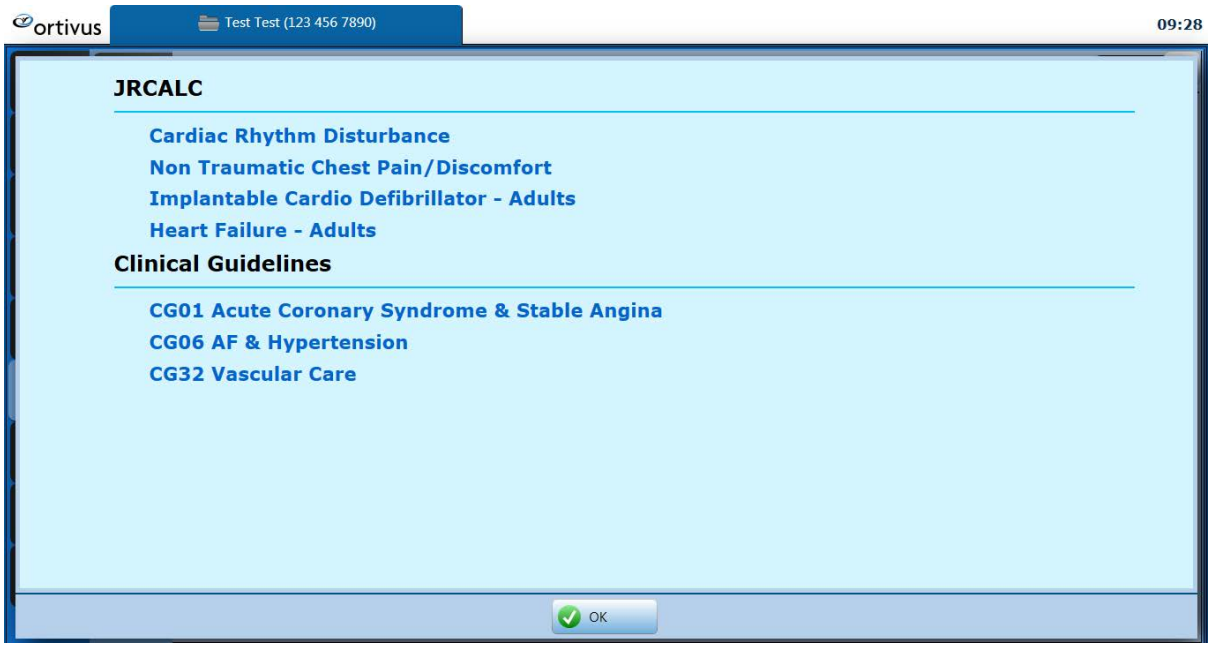
3.9 **Guidelines** have been placed on the EUD to support crews in determining the most appropriate action to take to deliver care to their patient. Guidelines can be accessed direct from the main menu screen and include, trust Clinical Guidelines, National guidelines from NICE and other clinical organisations, JRCALC and other useful operational documents.



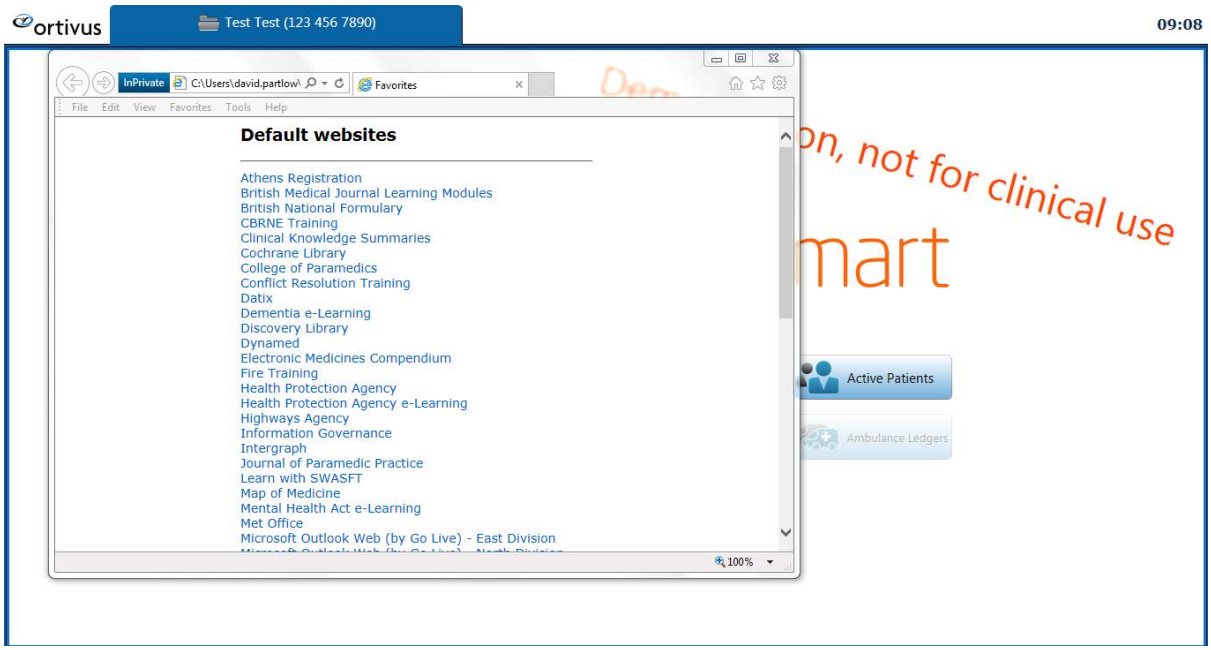
3.10 **Guidelines** and other relevant documents have also been placed within the configuration. These Guidelines are accessible by clicking on the Guidelines button within the ePCR. Guidelines within the configuration itself are placed to be relevant to the specific subject that is being presented on the screen



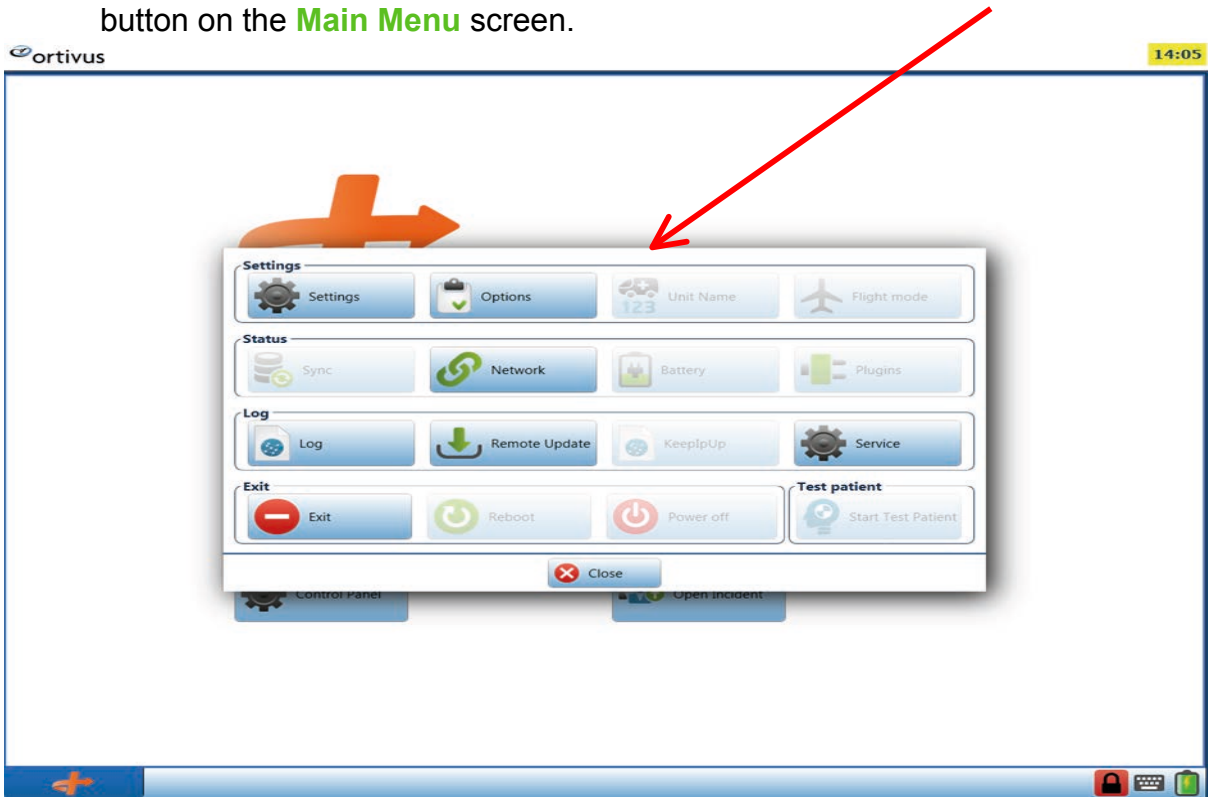
3.11 In the example above, once the **Guidelines** button has been selected, the documents as below are provided.



3.12 **Web Browser** provides access to a limited number of external websites. This can be used to access the Trust portal and user email accounts and also clinical websites such as Toxbase and Athens.



3.13 A number of additional features can be accessed via the **Control Panel** button on the **Main Menu** screen.

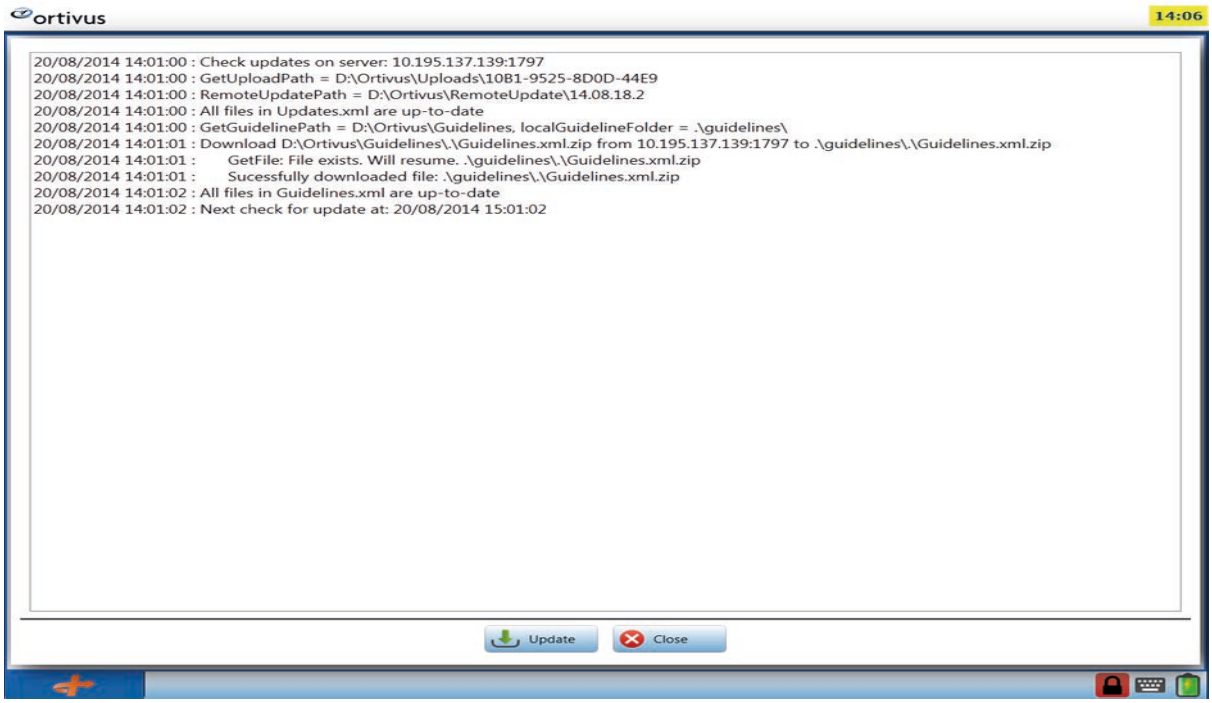


3.14 Information relating to network connection can be accessed by clicking on the **Network** button within the **Control Panel**. This information may be useful if connection to the server is lost and cannot be regained. The Logistics Team

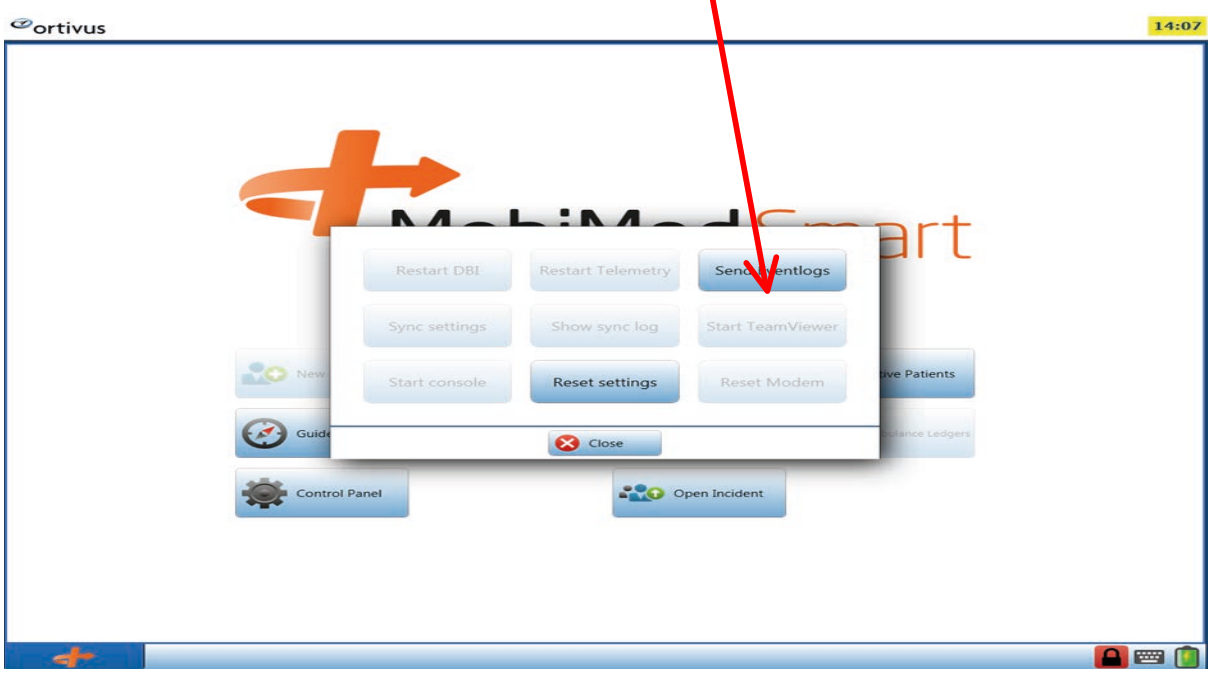
may request this information and prompt the user to ensure that they can access this information.

3.15 **Updates** will periodically be available for the EUD, this may take the form of new guidelines for example or changes to update the configuration. The Remote Update function allows the software to be updated remotely without a physical connection to the server.

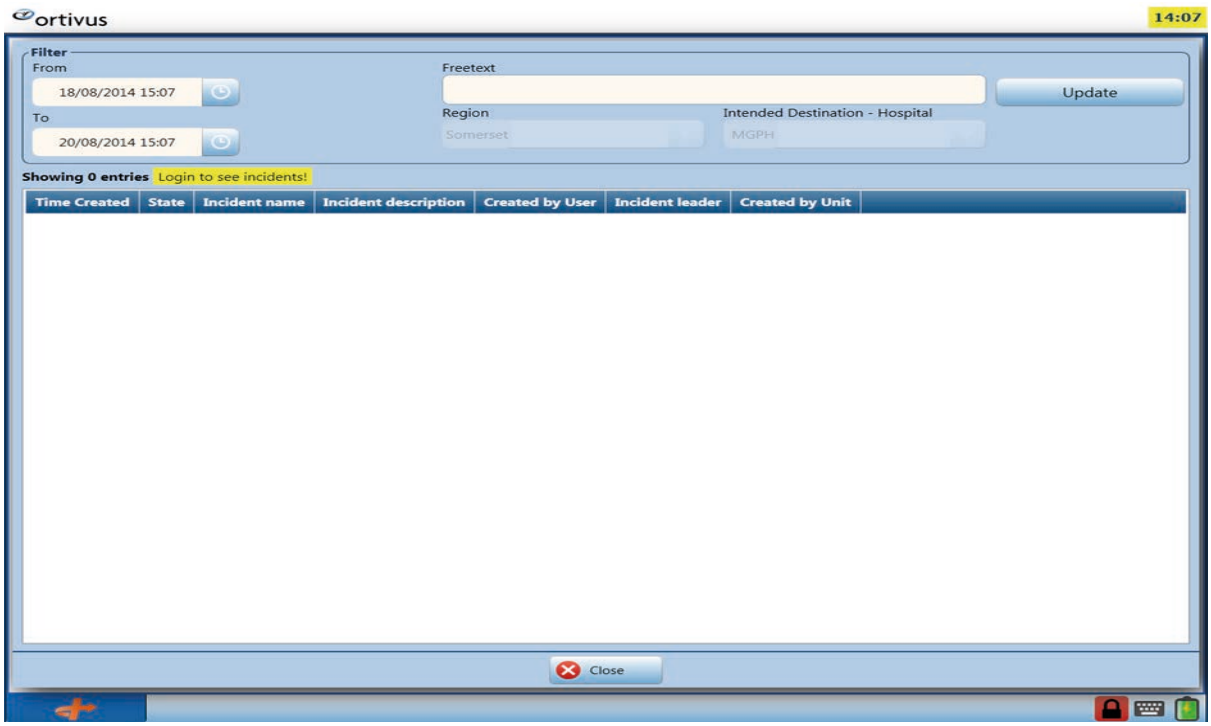
3.16 When updates are available the green **Update** icon will appear in the bottom right of the screen and the update can be accessed via the **Control Panel**.



3.17 The **Settings** function within the **Control Panel** allows the user to access functions such as synchronisation of settings between the EUD and the Server. This screen also allows the user to **Send Eventlogs**, this captures all data over a period of time and allows Ortivus to then analyse that data. This is very important if the device fails or any operation does not work as expected. The user must click on **Send Eventlogs** as soon as possible after the identification of any fault.



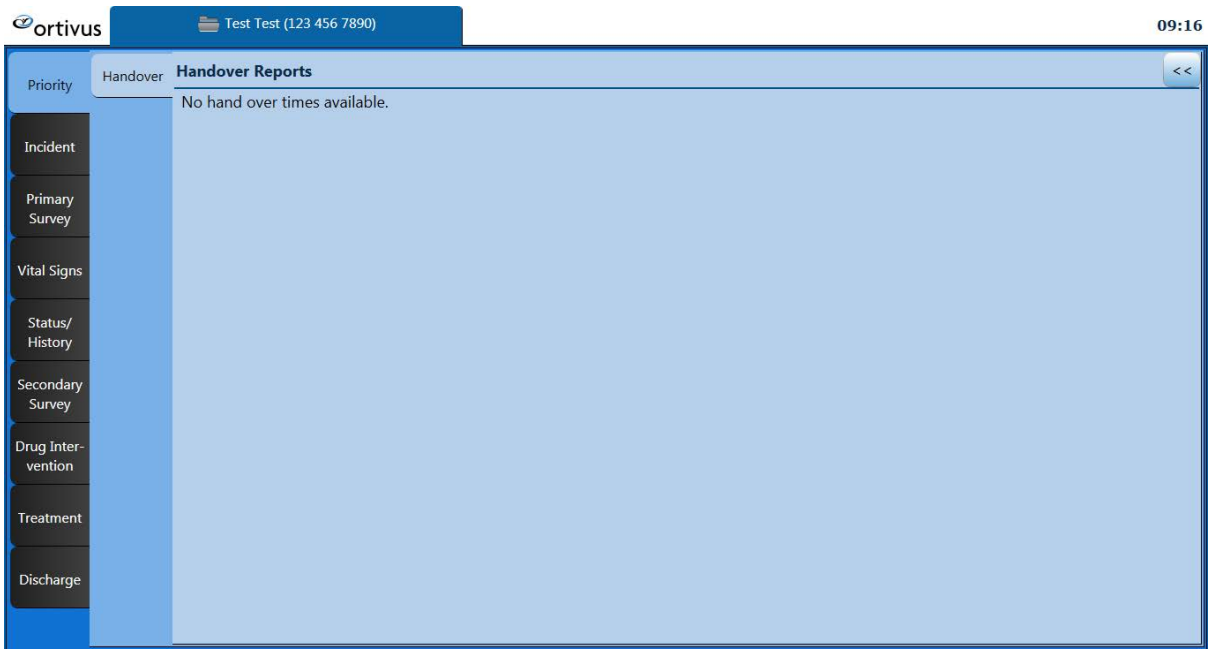
3.18 The **New Incident** and **Open Incident** buttons on the man menu screen enable the user to create an incident with multiple casualties and to manage those patients, by creating ePCRs for these patients and to then manage the ambulance resources and allocation of patients to those resources.



4. Electronic Patient Clinical Record

4.1 Primary Tab - Priority

4.1.1 The Priority tab does not currently provide any functionality, this is incorporated into future developments to support the clinician.



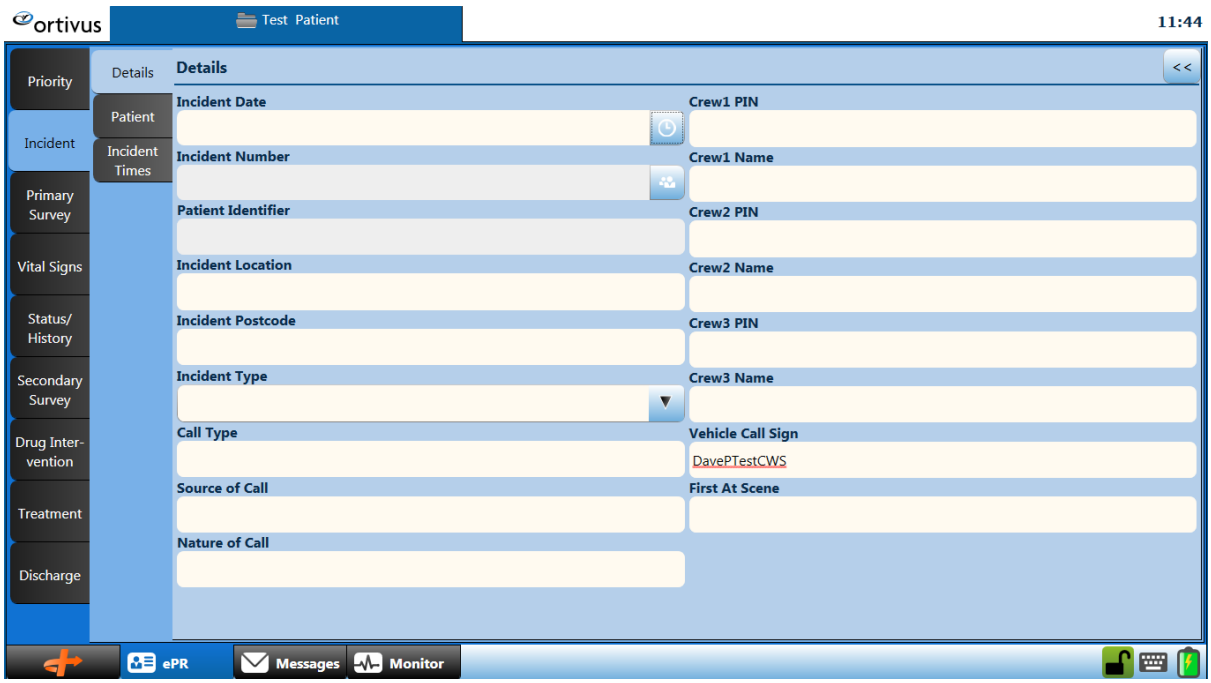
4.2 Primary Tab - Incident

4.2.1 Data captured within the **Details Screen** relate to the information provided by the caller into the 999 system. Data will be captured within the Computer Aided Dispatch system (CAD), this data will then be auto-populated within the fields shown.

4.2.2 Any data field that is pre-populated can be over-ridden by the clinician.

4.2.3 Auto population is achieved by clicking on the **Incident Number** button and selecting the appropriate incident that has been dispatched to the vehicle.

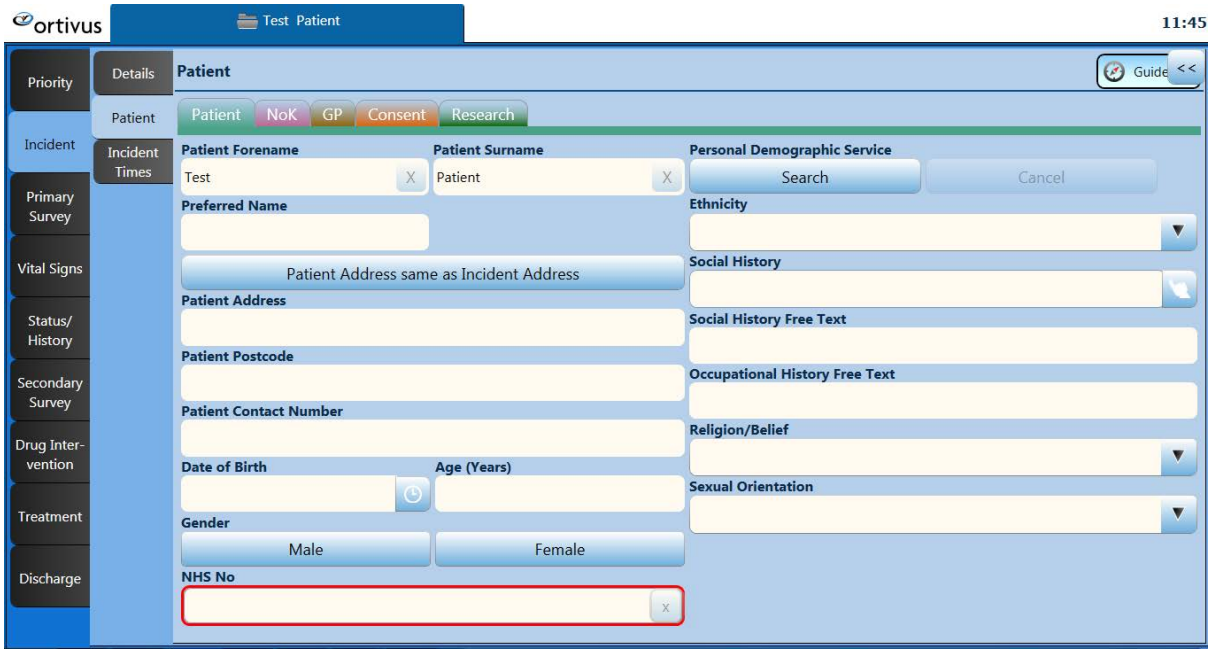
4.2.4 Should the clinician commence ePCR completion whilst out of signal, the clinician can continue with data entry until such time as the vehicle connects to the network. At this time the clinician can click on the **Incident Number** button and select the appropriate incident. Should any data fields that are CAD auto-populated be manually entered, they will be over-ridden by the data entered into CAD. For example if the Clinical Hub have entered the patient as "John Jones" and the clinician has subsequently found the patient to be "June Jones", this will be over-ridden by CAD push and will need to be re-entered.



4.2.5 The **Patient Screen** enables the clinician to enter information relating to the Patient. It includes the option to add a preferred name, or a name by which the patient is known other than their primary christen name.

4.2.6 Additionally a **Patient Address same as Incident Address** button is available, by clicking this, the **Patient Address** fields will auto-populate with information captured in CAD relating to the **Incident Address**.

4.2.7 Drop down boxes are provided to support the capture of standard demographics including **Ethnicity**, **Social History**, **Religion** and **Sexual Orientation**. Additional free text fields are provided for **Social History** and **Occupational History**. Information relating to the nature of the patient's occupation may be important for hand fractures or injury relating to the ability to care for a dependant or to drive for work etc.

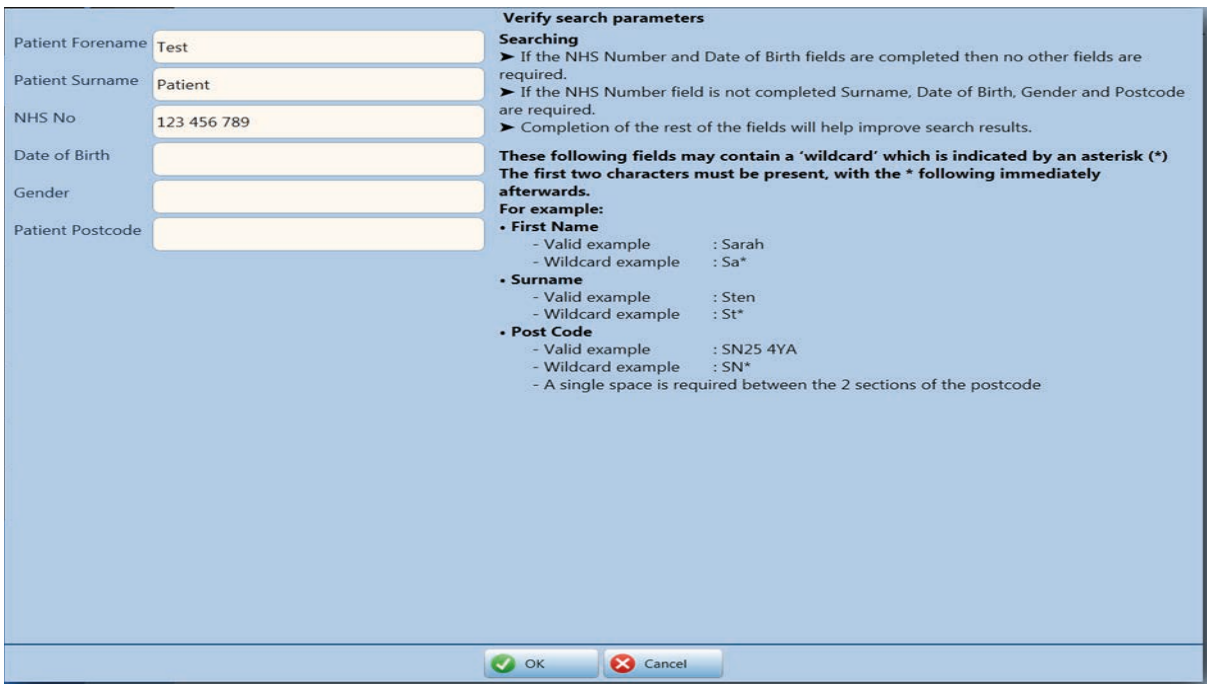


4.2.8 Everyone registered with the NHS in England and Wales has their own unique number. This is provided in writing when initially registered with a GP practice. The **NHS Number** helps healthcare staff to find and integrate health care records. Each NHS Number is made up of 10 digits shown in a 3-3-4 format.

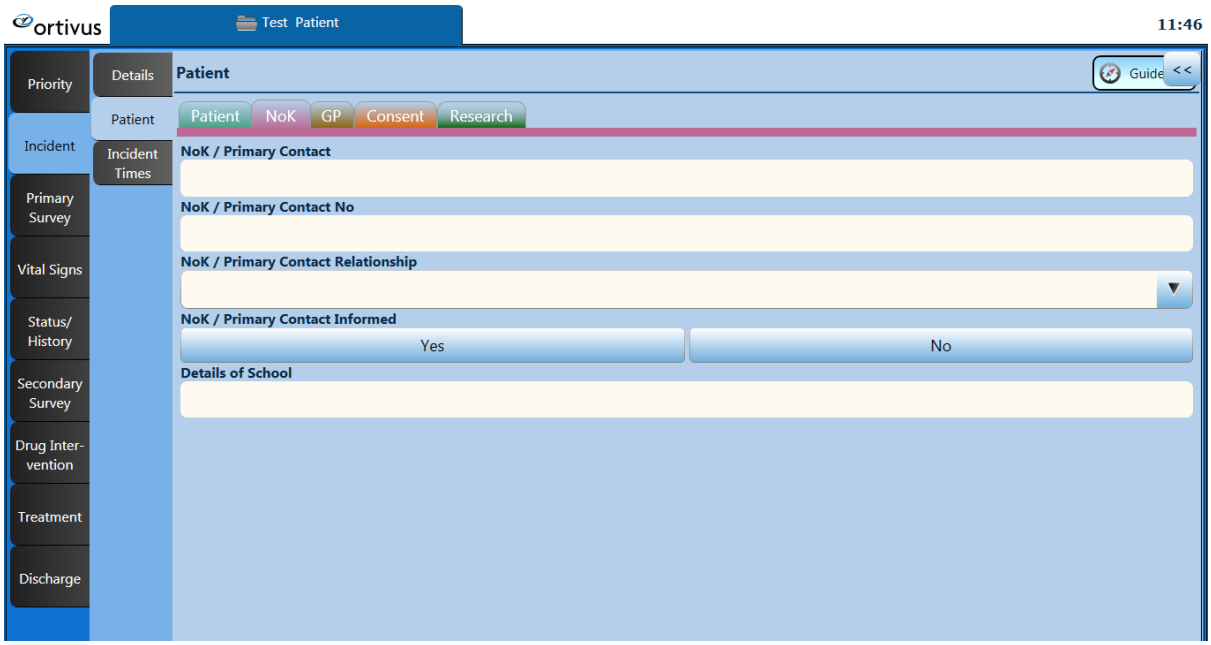
4.2.9 As efforts to standardise electronic patient data increases and system integration becomes a reality, the **NHS Number** will become ever more central to the management of patient identifiable data. It is therefore vital that this information is captured where possible and entered onto the record.

4.2.10 The **NHS Number** can be found on any correspondence that the patient may have from hospital or from their GP and is often included on repeat prescription documentation.

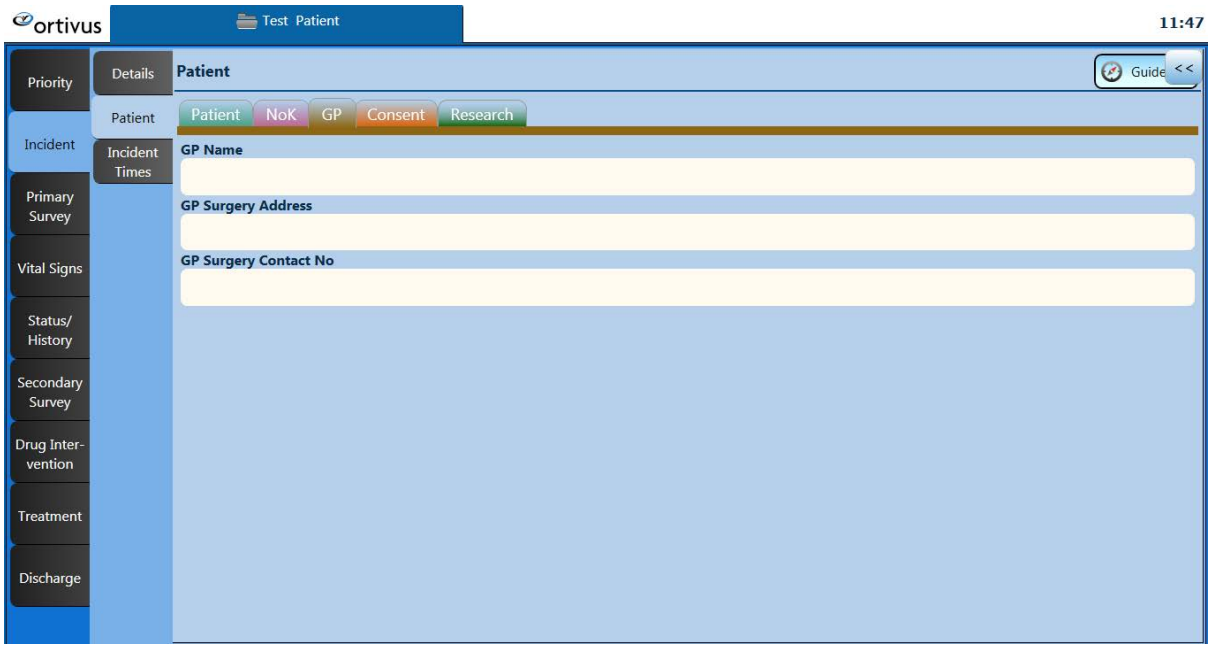
4.2.11 Additional functionality has also been provided within the ePCR to search the "NHS Spine", and pull the relevant information into the ePCR. This is achieved via a **Patient Demographic Service** button which brings up the screen below. Once the information entered is validated the NHS Spine will then be searched and appropriate data collected.



4.2.12 **NoK** or Next of Kin information is entered into this page, it is important that a mobile or other contact number is entered if the next of kin is not accompanying the patient. This will enable the hospital to make contact should they require any additional information which is currently not entered or to discuss ongoing plans for the care of the patient.



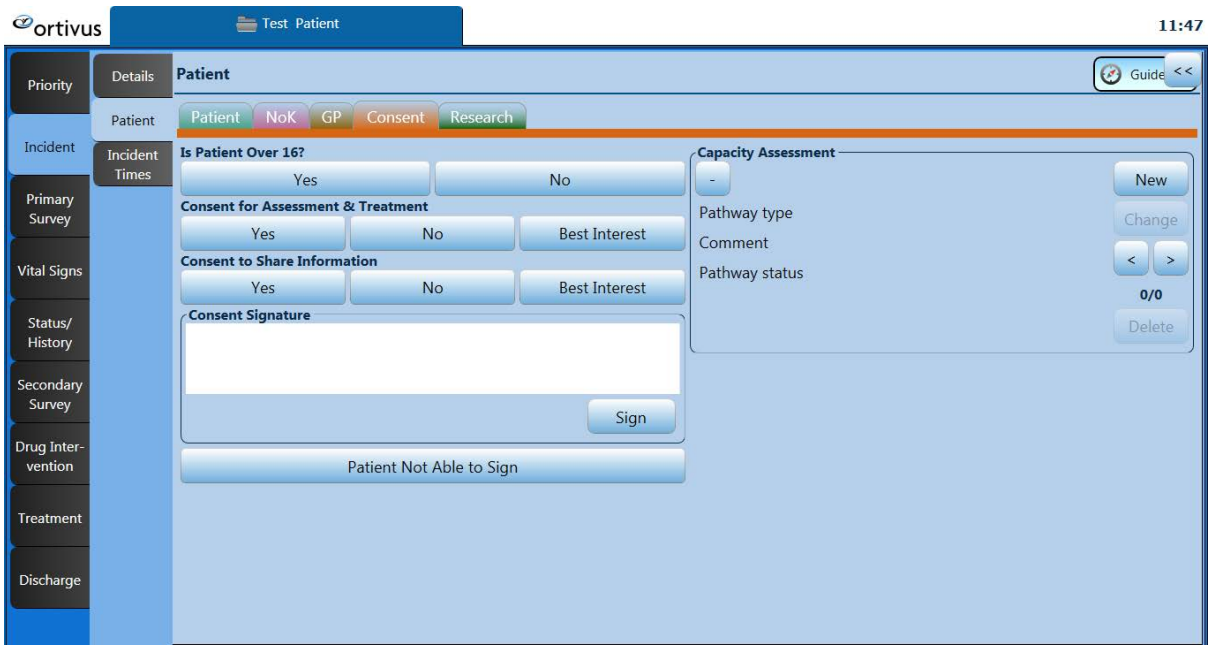
4.2.13 Details of the patients **General Practitioner** (GP) are entered within this screen, they may be manually inputted or pulled from the NHS Spine on successful identification of the **NHS Number**.



4.2.14 Any patient assessment and subsequent treatment plan should be conducted with the **Consent** of the patient. Additionally the transfer of that information to another health provider should be undertaken with the consent of the patient. This does not however require that every patient counter sign to support the consent process.

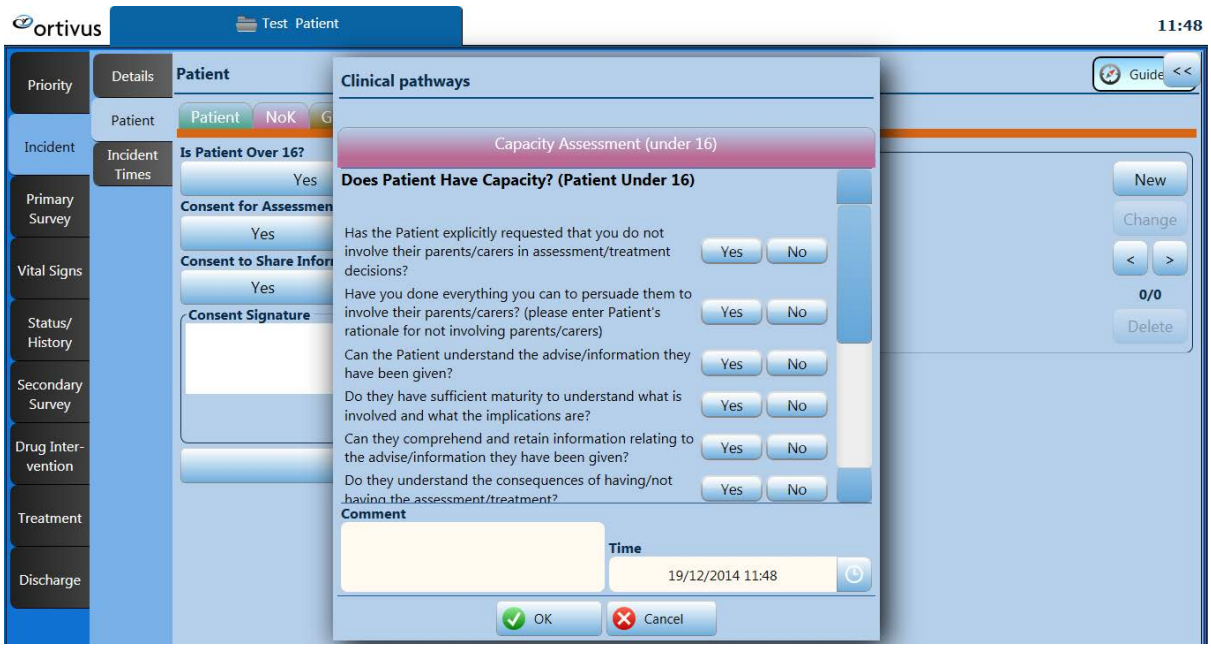
4.2.15 Should a patient refuse to allow the Trust to **share** their **information**, the patient should be made aware that any subsequent care plan will be compromised. The ePCR system will inhibit the electronic transfer of data if the **No** to consent is clicked.

4.2.16 Should the patient not provide consent and the clinician determines that they do not have capacity to make that decision or believes that the **Best Interests** of the patient outweigh that decision, a free text box will appear on clicking **Best Interest**, the clinicians rationale must be entered here.

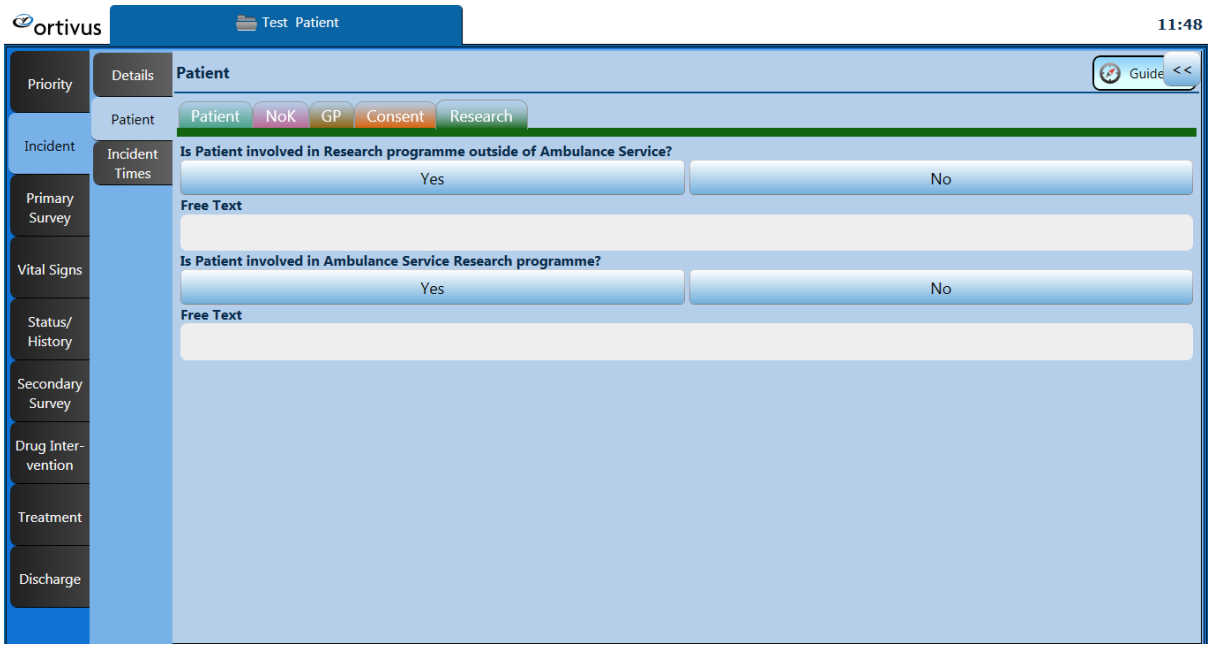


4.2.17 The **Mental Capacity** Act requires all clinicians to consider that all patients have the capacity to make decisions about their care until such time as the assessment of capacity determines otherwise. It is not sufficient to undertake an assessment and determine capacity without appropriately documenting the decision making process and rationale for any determination which subsequently impacts on the patients care.

4.2.18 By clicking the **New** button within the **Capacity Assessment** box, a checklist will appear to assist in the assessment of capacity. This assessment will be based on an adult capacity assessment if the **Is the Patient Over 16** box is ticked **Yes** and on paediatric competency if the **Is the Patient Over 16** box is ticked **No**.

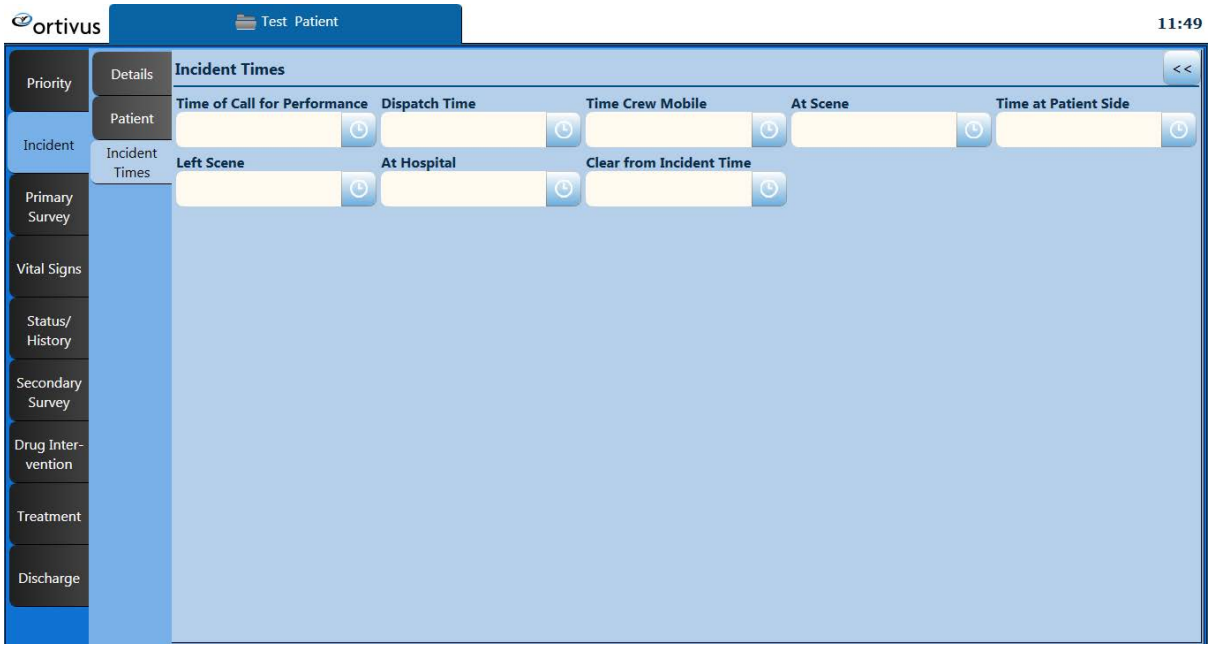


4.2.19 The **Research** tab is used only to record patients who are known to be currently enrolled in Trust Research project or in an external health research project.



4.2.20 All timings related to the patient engagement are directly fed from CAD, with the exception of **Time at Patient Side**, this must be manually entered.

4.2.21 Any patient incident time auto-populated via CAD can be overridden by the clinician.



4.3 Primary Tab – Primary Survey

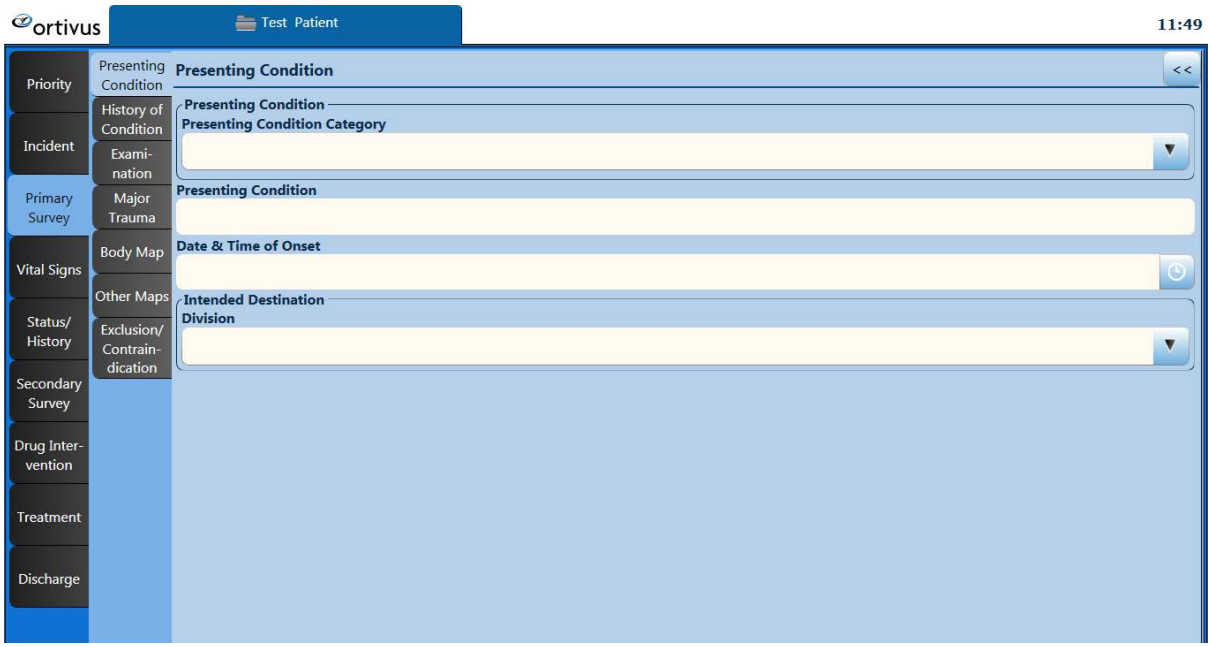
4.3.1 The **Presenting Condition Category** drop down list accessed by clicking the black triangle presents the clinician with a number of clinical categories such as cardiac or trauma. Once selected a second drop down will appear which provides a list of sub categories, for example in Cardiac there is STEMI? or within Trauma, Leg Injury or Head Injury Open.

4.3.2 The **Presenting Condition** box below allows the clinician to detail in free text format anything that is pertinent to the nature of the patient's complaint. This free text box expands as the clinician types to allow for the completion of extensive notes. This should however be restricted to the nature of the illness or injury and not replace or duplicate data fields elsewhere within the configuration.

4.3.3 **Date and Time of Onset** allows the clinician to enter the point at which the present complaint originated. For ongoing or long standing concerns, this should be the point at which that concern became severe enough to require ambulance intervention.

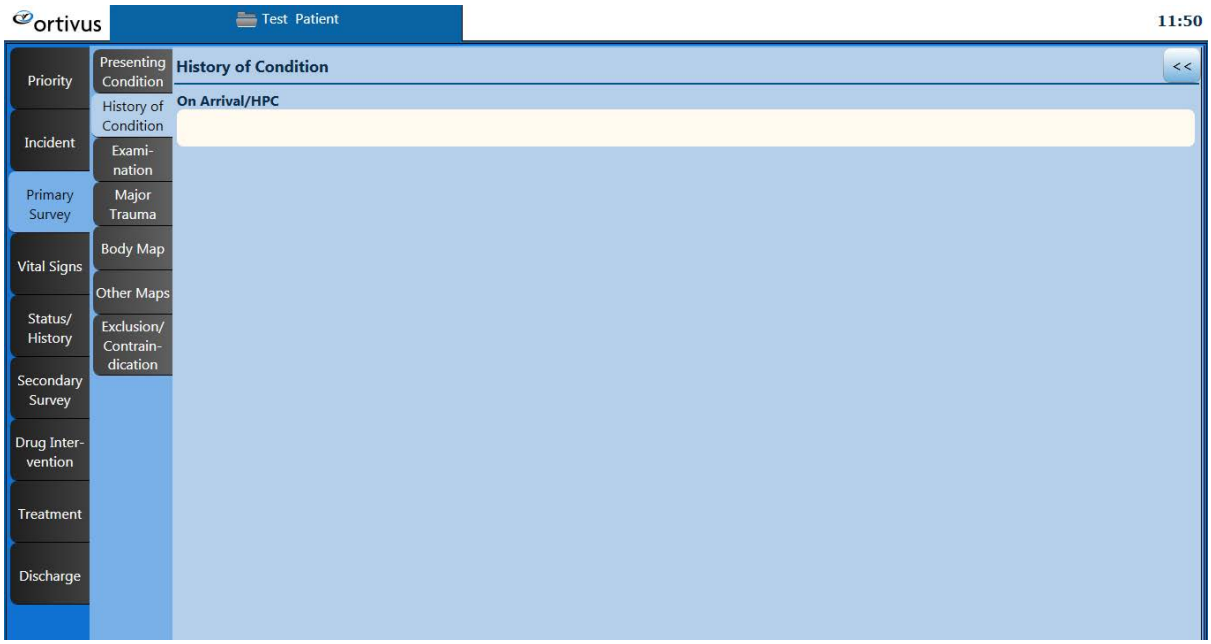
4.3.4 The **Intended Destination** fields open up drop down boxes so that the user can indicate which hospital they may be transferring the patient to. The three drop down boxes begin with **Division** then to **Hospital** and finally to the **Department** where the patient may be conveyed.

4.3.5 By selecting an appropriate destination the system opens up the technical link between the hospital and the server so that the receiving hospital department can access the patient identifiable information. If this drop down functionality is not used, the receiving department will not be able to view the record until such time as the ambulance arrives.



4.3.6 The clinician can enter the narrative, or “story” behind the patients illness or injury within the **History of Condition**,. **On Arrival/History of Presenting Condition (HPC)** field.

4.3.7 This information is entered within free text format and as with other free text fields this will expand to allow the clinician to enter significant history. This free text should however be restricted to the history of the patients illness or injury and should not replace or duplicate data fields contained elsewhere within the configuration.

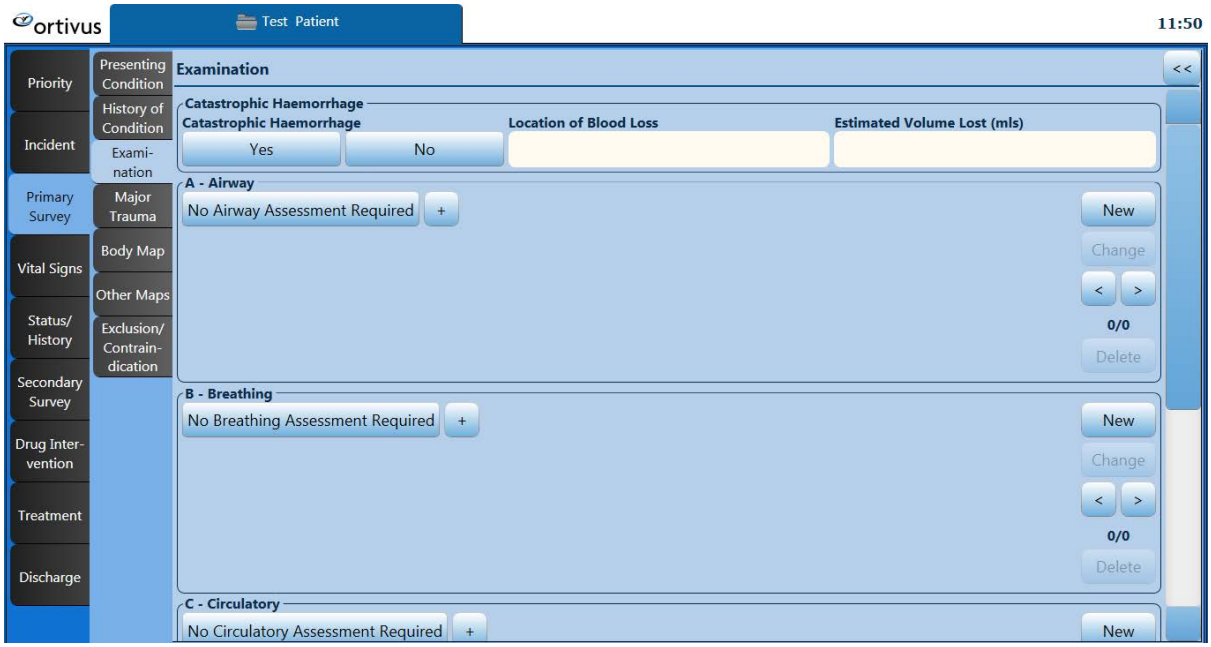


4.3.8 The assessment of **Catastrophic Haemorrhage** and evaluation of A (Airway), B (Breathing), C (Circulation) and D (Disability) are been incorporated into a single screen.

4.3.9 The functionality of **Airway**, **Breathing**, **Circulatory** and **Disability** assessments incorporates a, **No Assessment is Required** functionality. For example a patient complaining of a broken finger does not require the clinician to document their airway competency and breathing status. This allows the clinician to quickly annotate that this assessment was not required and to move on to the secondary survey without complication.

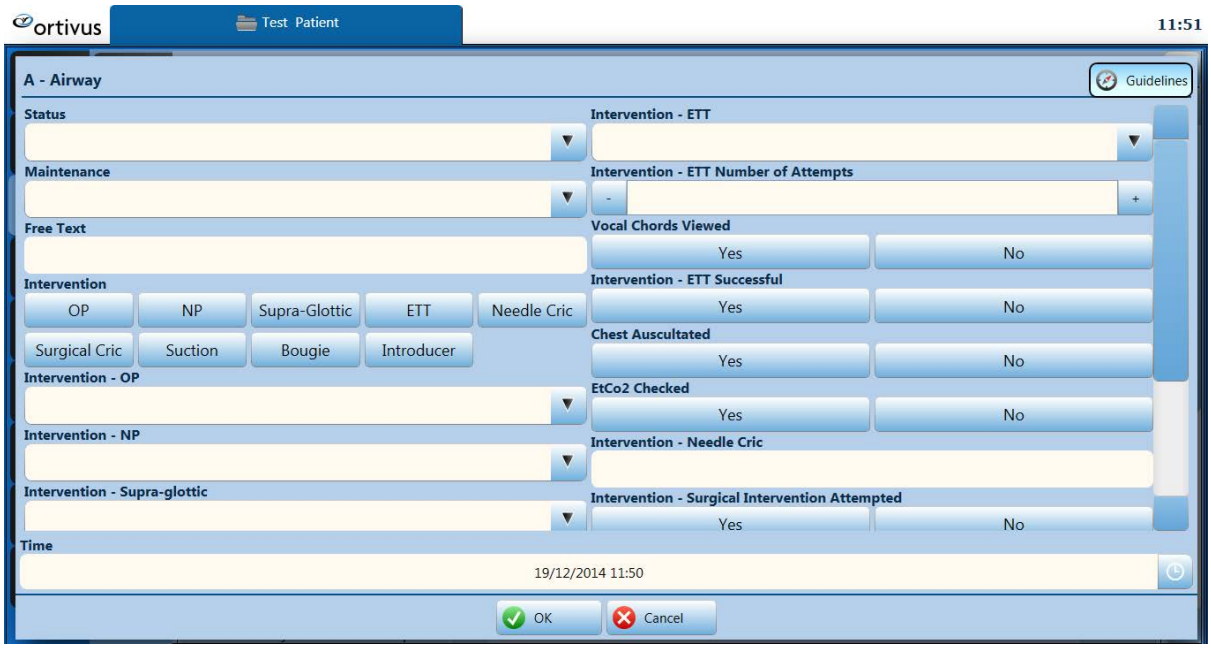
4.3.10 Should an assessment be required, the **New** assessment button opens up the assessment page as below.

4.3.11 Should the clinician wish to conduct multiple assessments and wish to see previous outcomes, the **+** button opens up the previous assessments for review.



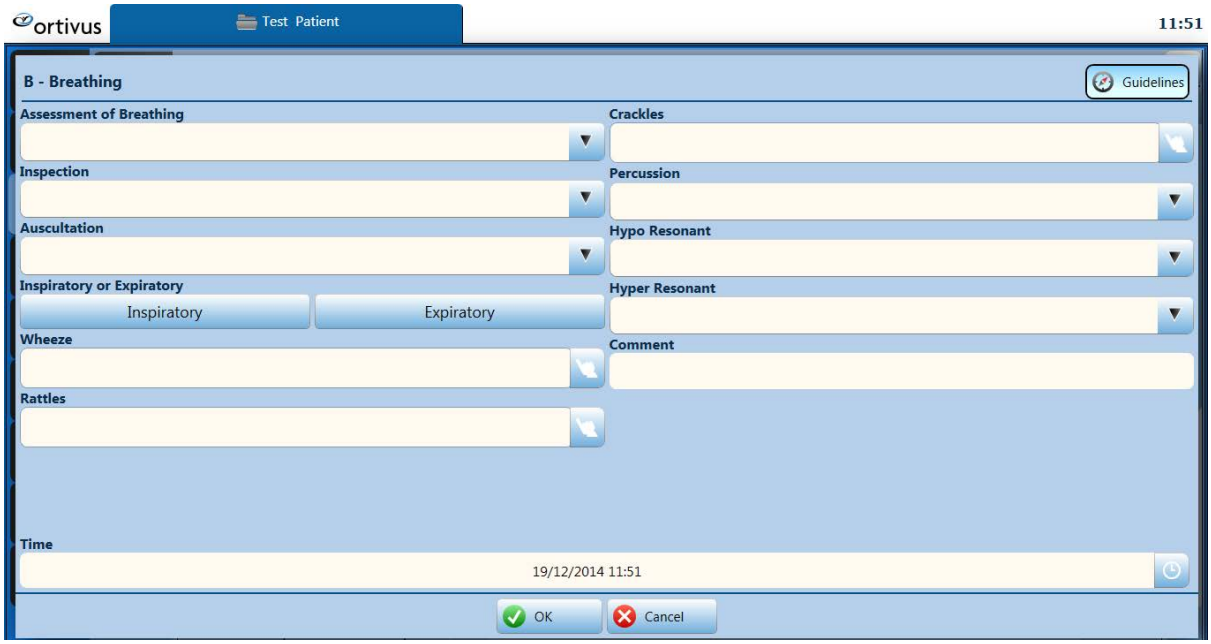
4.3.12 Should a **New**, **Airway Assessment** be required, the screen below will be displayed. This enables the clinician to document the status of the airway and any interventions required to maintain that airway.

4.3.13 Most data entered within this screen is via drop down menus, however some free text is provided to capture data not felt to be relevant to any specific field.



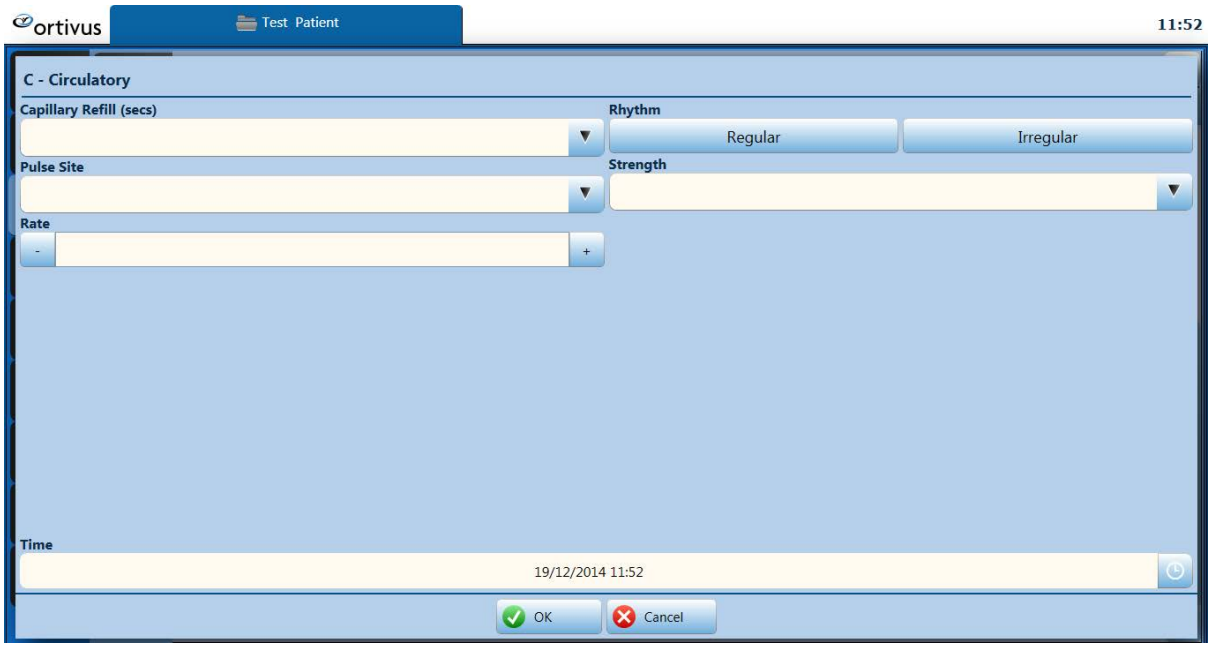
4.3.14 Should a **New**, **Breathing Assessment** be required, the screen below will be displayed. This enables the clinician to document the assessment of the patients breathing, including the findings of auscultation and percussion.

4.3.15 Most data entered within this screen is via drop down menus, however some free text is provided to capture data not felt to be relevant to any specific field.



4.3.16 Should a **New**, **Circulatory Assessment** be required, the screen below will be displayed. This enables the clinician to document the findings of their assessment of any circulatory compromise.

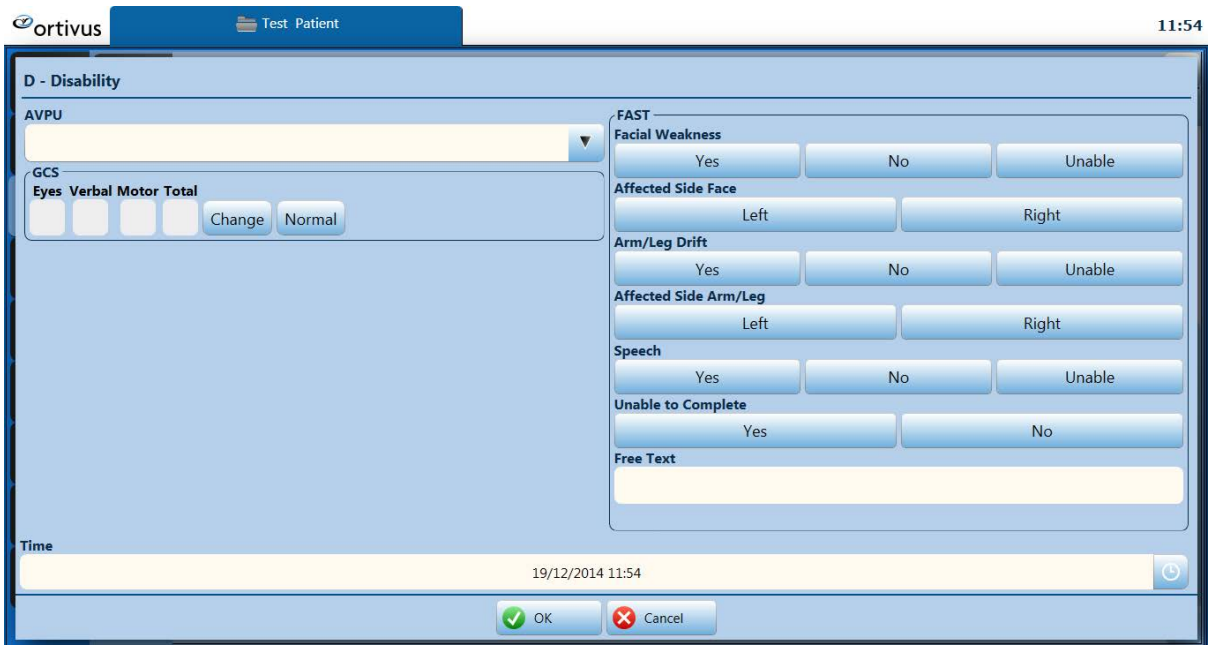
4.3.17 Data entered within this screen is via drop down menus.



4.3.18 Should a **New**, **Disability Assessment** be required, the screen below will be displayed. This enables the clinician to document the assessment of the patients conscious level, their **GCS** and a **FAST** test.

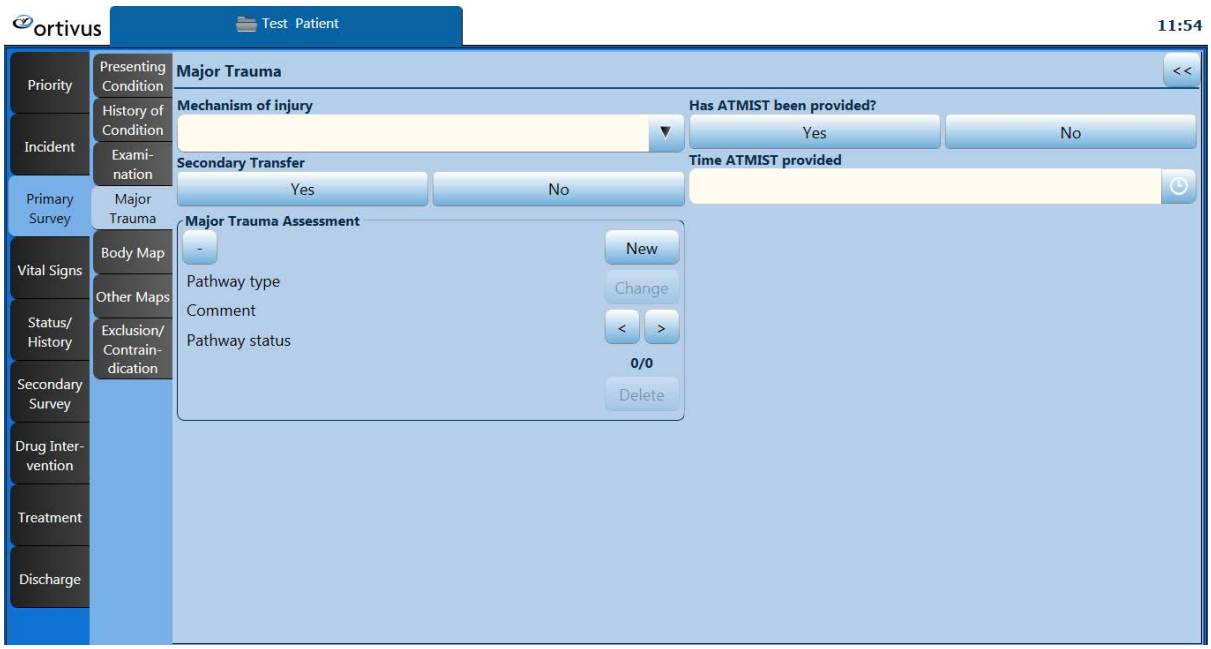
4.3.19 The GCS provides the ability to click **Normal** for any patient who has a GCS of 15 or for the clinician to click on **Change** to review the Eye, Voice and Motor scores individually. This also supports a GCS for both Adult and Child.

4.3.20 Most data entered within this screen is via drop down menus, however some free text is provided to capture data not felt to be relevant to any specific field.



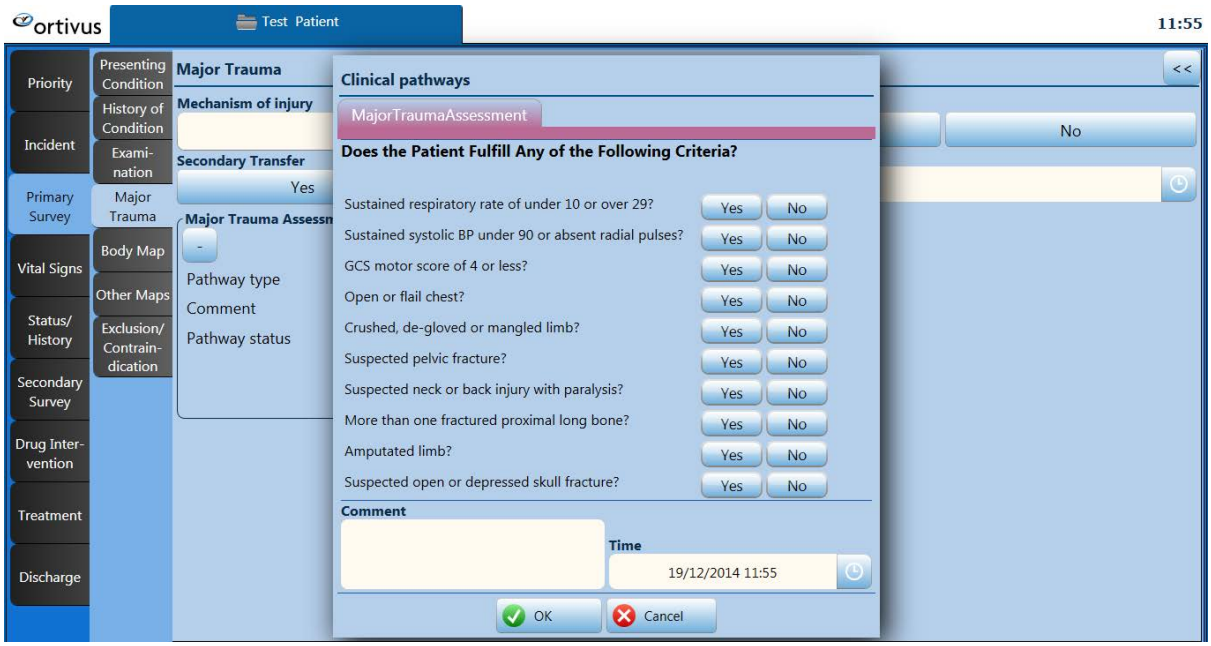
4.3.21 The **Major Trauma** Screen provides the clinician with a drop down menu to select the Mechanism of Injury, whether this be from a RTC (Road Traffic Collision) or from a Fall.

4.3.22 This screen also requires the clinician to confirm whether an **ATMIST** pre alert has been provided to the receiving hospital and if so at what time that ATMIST occurred.



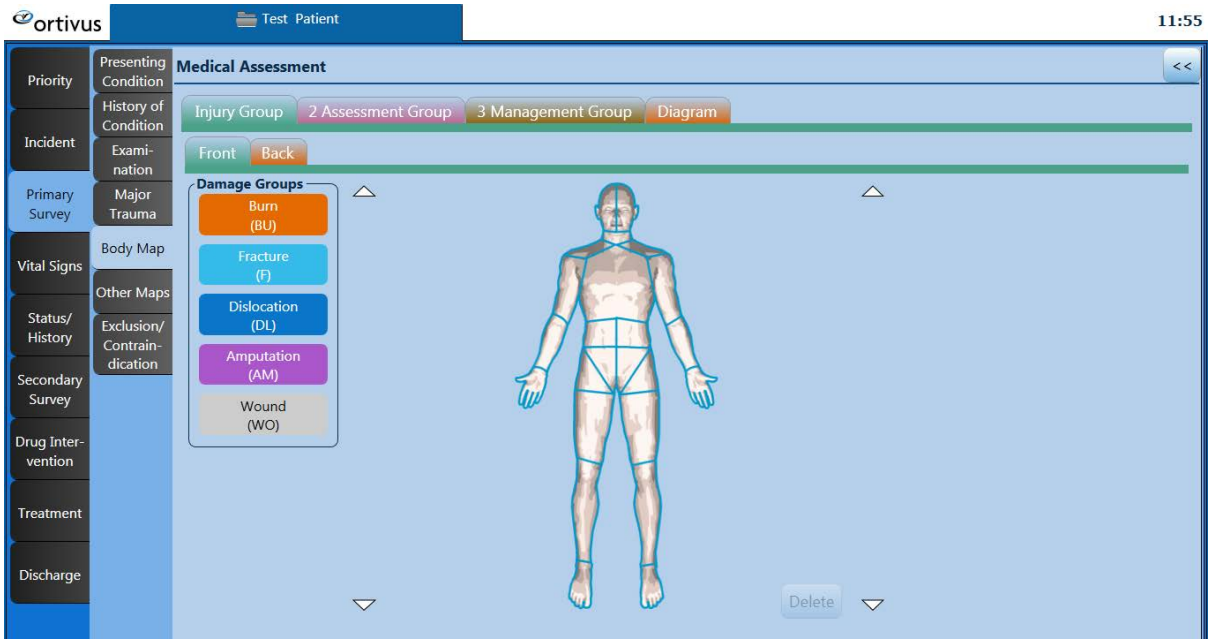
4.3.23 Should the clinician consider that the patient may activate the Wessex Trauma Triage Tool they should undertake the **Major Trauma Assessment**. This provides a drop down checklist which supports the clinician in undertaking the Wessex Trauma Triage Tool and supports the clinician in making a decision as to the most appropriate receiving unit for the patient.

4.3.24 This tool is a support for the clinician and does not remove the clinical responsibility nor does it determine the course of action to be followed. By clicking Yes or No as appropriate the tool will generate an output based on the Wessex Trauma Triage Tool and suggest an outcome based on that tool.



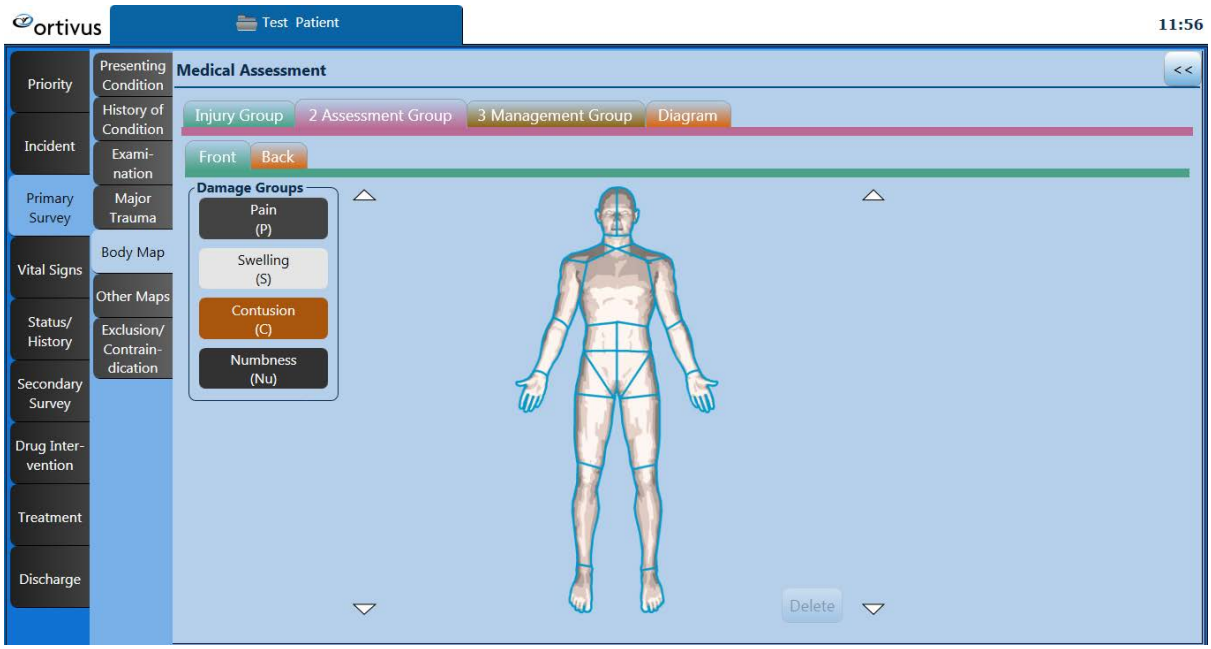
4.3.25 The **Body Map** screens enable the user to annotate a body map, either from a view of the **Front** of the patient or from a view of the **Back** of the patient. This identifies the position on the body of a **Burn**, **Fracture**, **Dislocation**, **Amputation** or **Wound**.

4.3.26 The clinician clicks on the relevant button, then on the body to show location. This opens up a separate data entry field for the capture of information relating to that **Injury**.



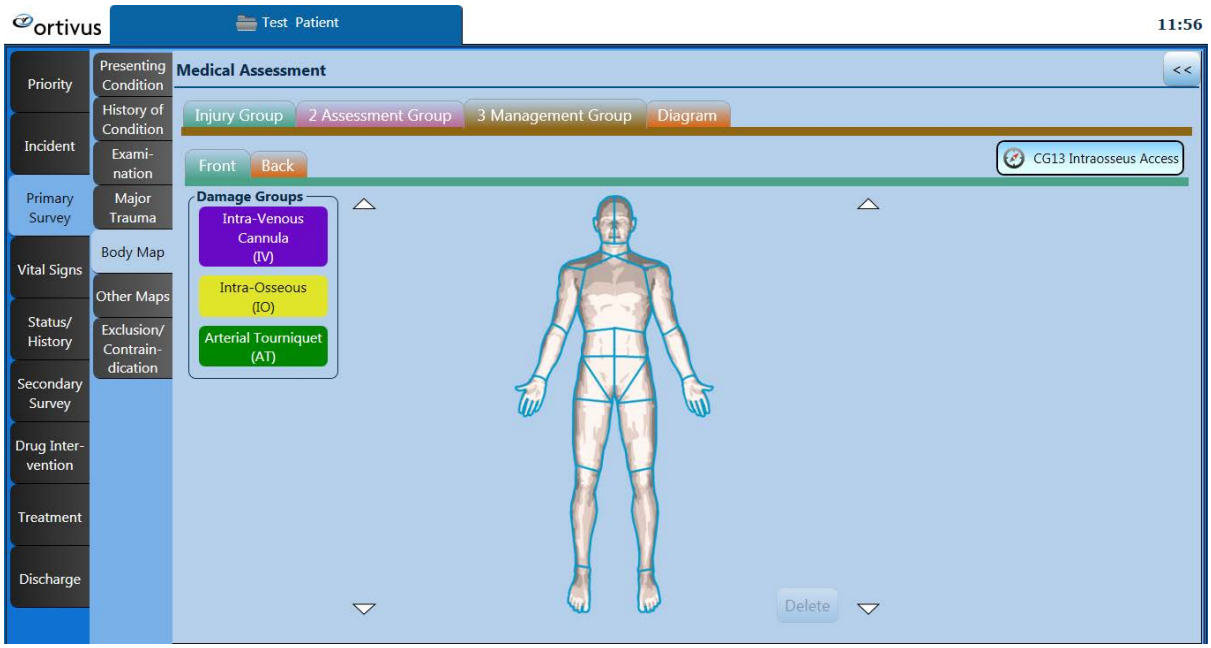
4.3.27 The Body Map screens enable the user to annotate a body map, either from a view of the **Front** of the patient or from a view of the **Back** of the patient. This identifies the position on the body of **Pain**, **Swelling**, **Contusion** or **Numbness**.

4.3.28 The clinician clicks on the relevant button, then on the body to show location. This opens up a separate data entry field for the capture of information relating to that **Assessment**.



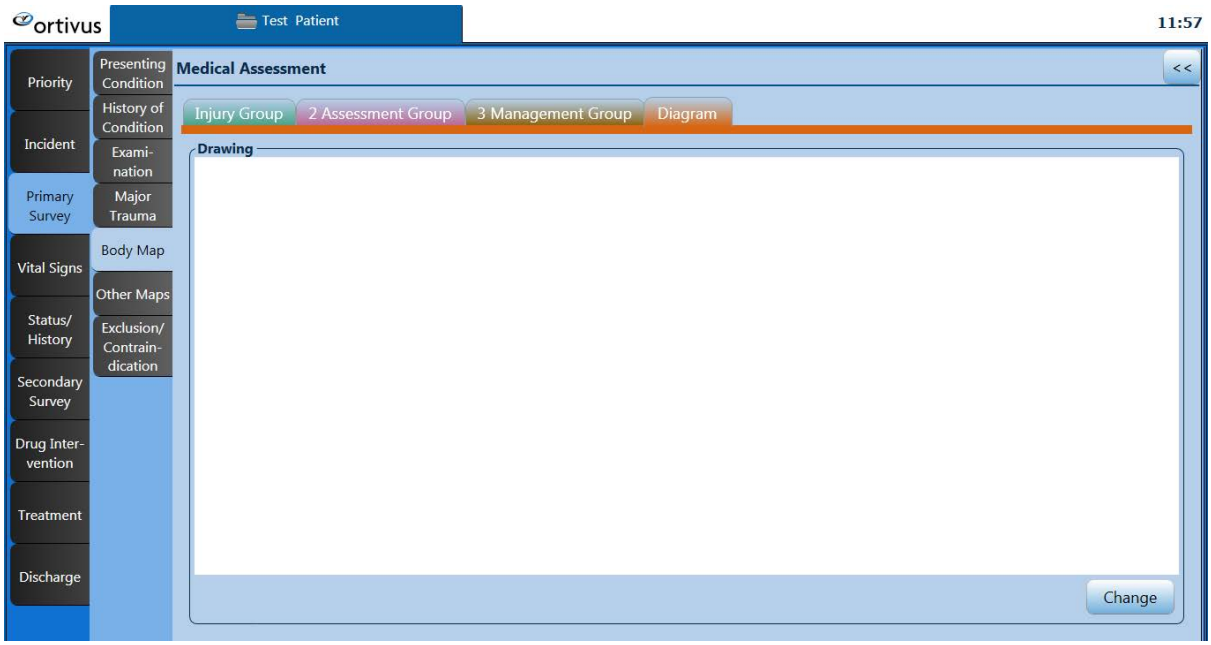
4.3.28 The Body Map screens enable the user to annotate a body map, either from a view of the **Front** of the patient or from a view of the **Back** of the patient. This identifies the position on the body of an intervention relating to the placement of **Intra-Venous Cannula**, **Intra-Osseous**, or **Arterial Tourniquet**.

4.3.29 The clinician clicks on the relevant button, then on the body to show location. This opens up a separate data entry field for the capture of information relating to that **Management**.

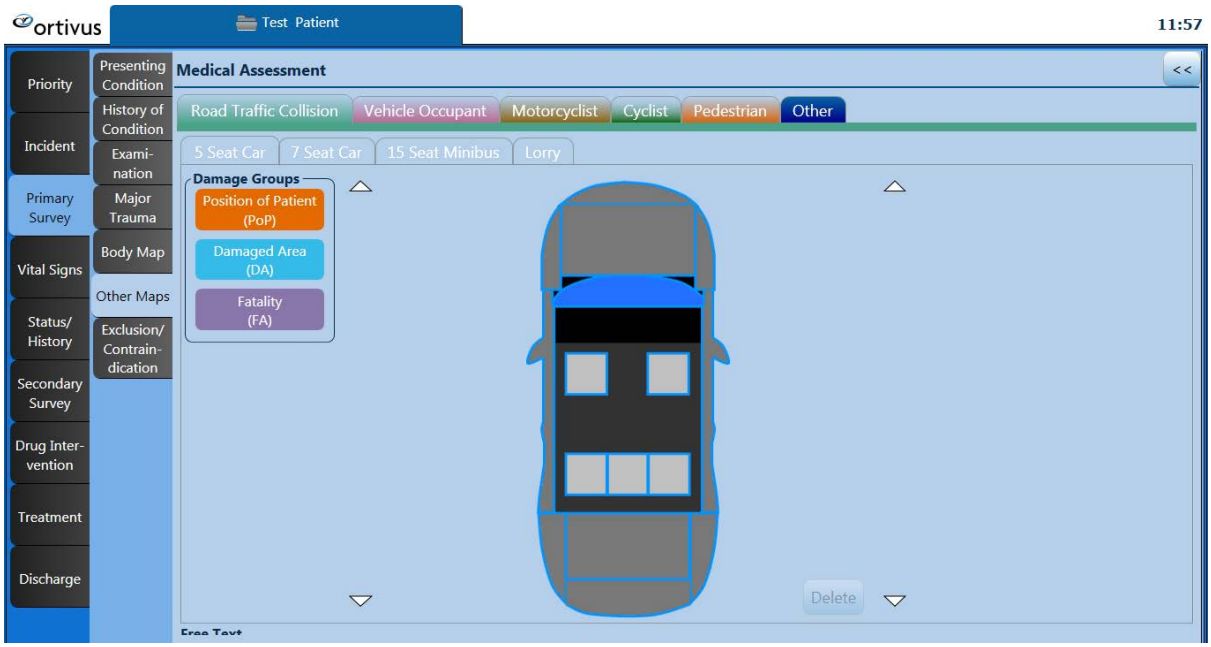


4.3.30 In order to allow the clinician to free hand draw a diagram or pictorial representation of the wound or injury etc, a large free text drawing box is provided.

4.3.31 The clinician clicks on **Change** and then uses the stylus provided to draw onto the screen the image they require.

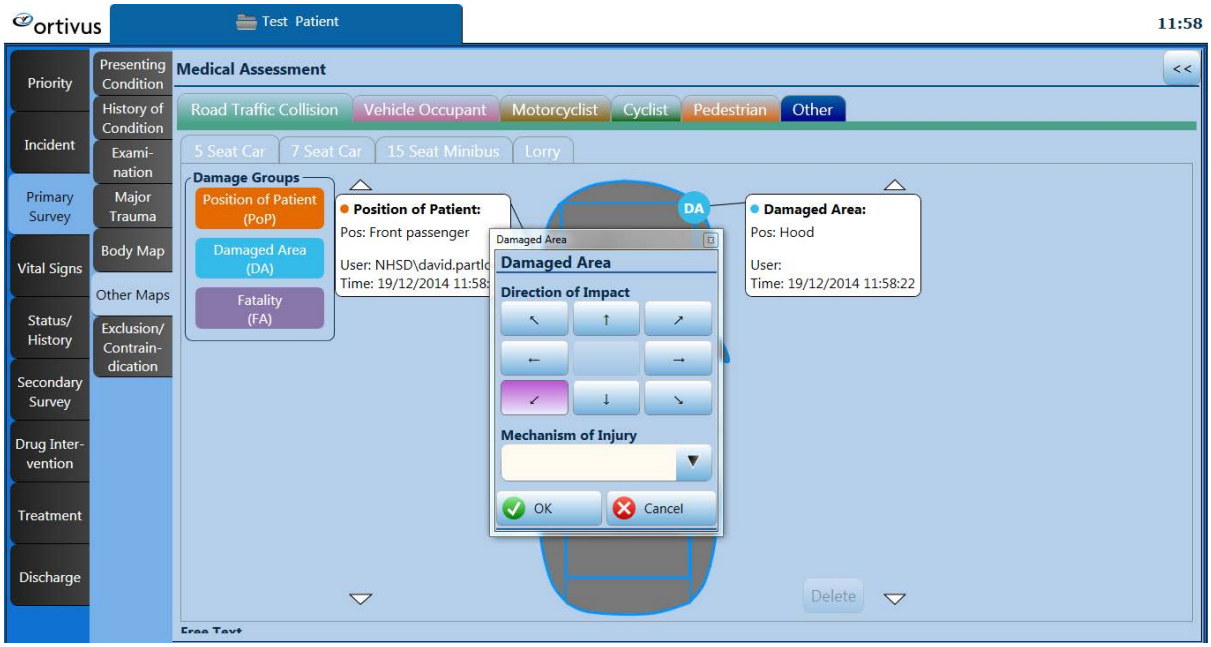


4.3.32 **Other Maps** provides the clinician with the opportunity to document in pictorial format the positioning of patients and damage to a series of vehicles at a Road Traffic Collision.

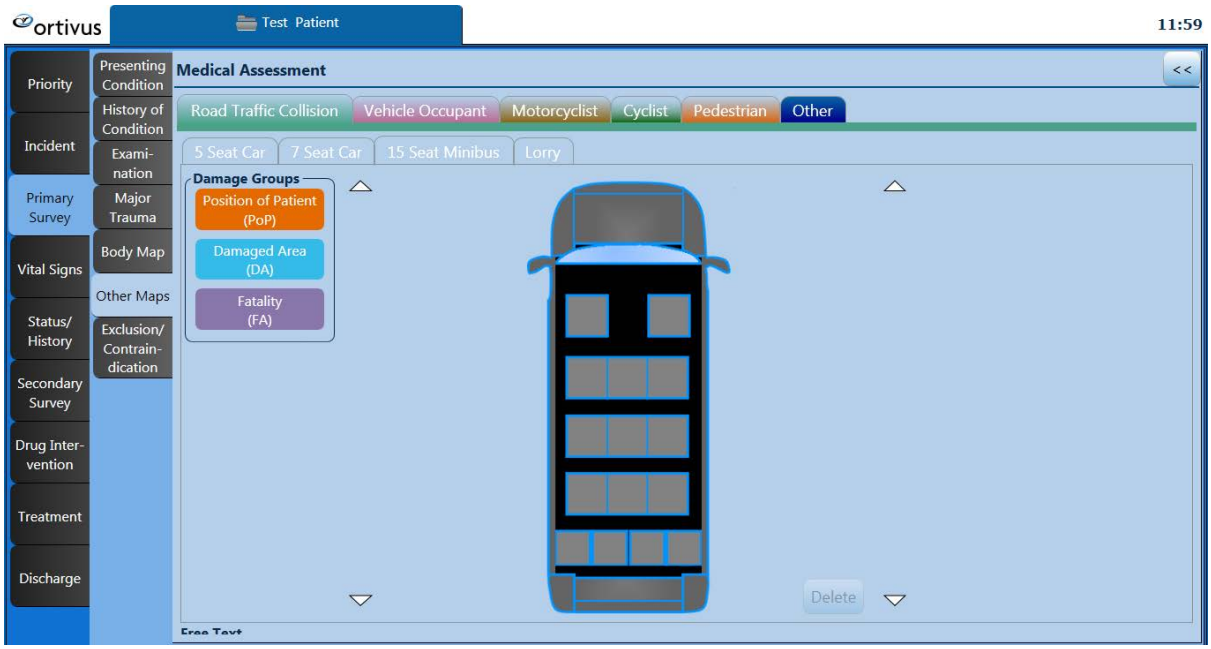


4.3.33 The **Position of Patient** and or **Fatality** can be entered on to the car by clicking on the appropriate box and then on to the position on the car.

4.3.34 In order to document the damage caused to the vehicle and the **Direction of Impact**, the clinician clicks on **Damaged Area** and then on to the point of impact on the vehicle, the direction through which that impact occurs can be annotated using the available arrows.

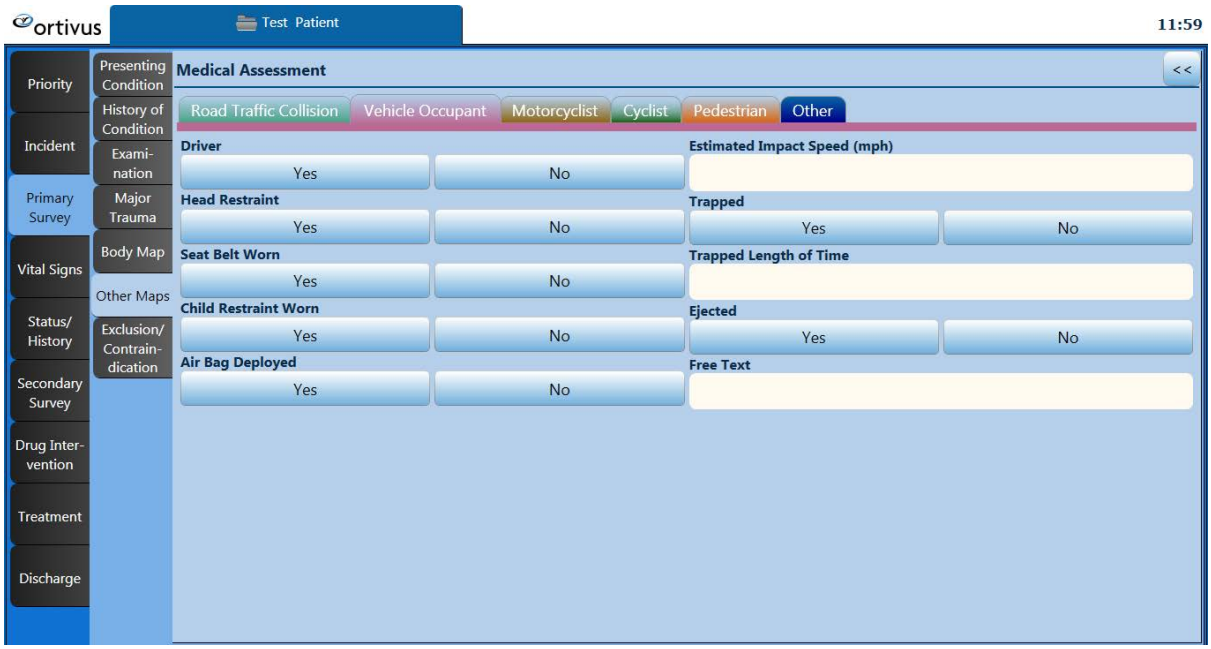


4.3.35 The functionality relating to placement of pictorial information as described previously relating to a **5 Seat Car** is also duplicated on a **7 Seat Car**, **15 Seat Minibus** and **Lorry**.

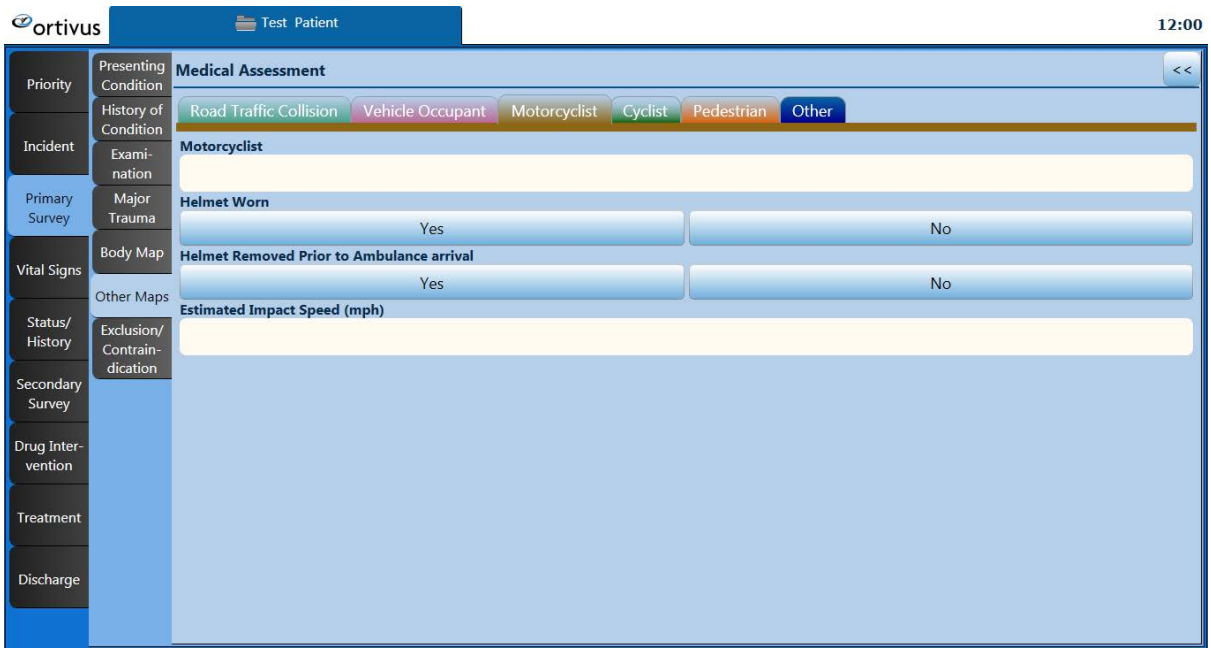


4.3.36 The **Vehicle Occupant** tab allows the clinician to enter data relating to a patient who has been subjected to an injury whilst in a vehicle. Information relating to **Head Restraint**, **Seat Belts** and **Estimated Impact Speed** etc are all important to convey a picture to the receiving clinician. Estimated Impact Speed is the combined speed at point of impact for incidents involving two vehicles.

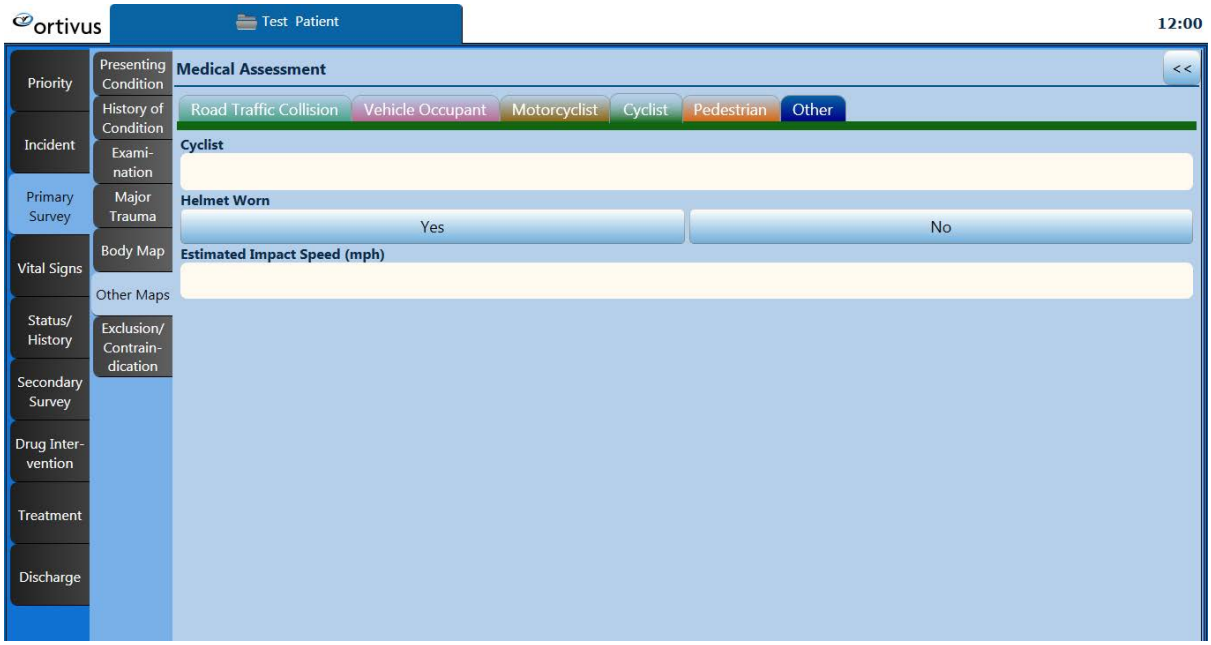
4.3.37 **Free text** field is provided should details such as the make and model of vehicle, condition of road, weather at time of incident etc be relevant to any ongoing care plan.



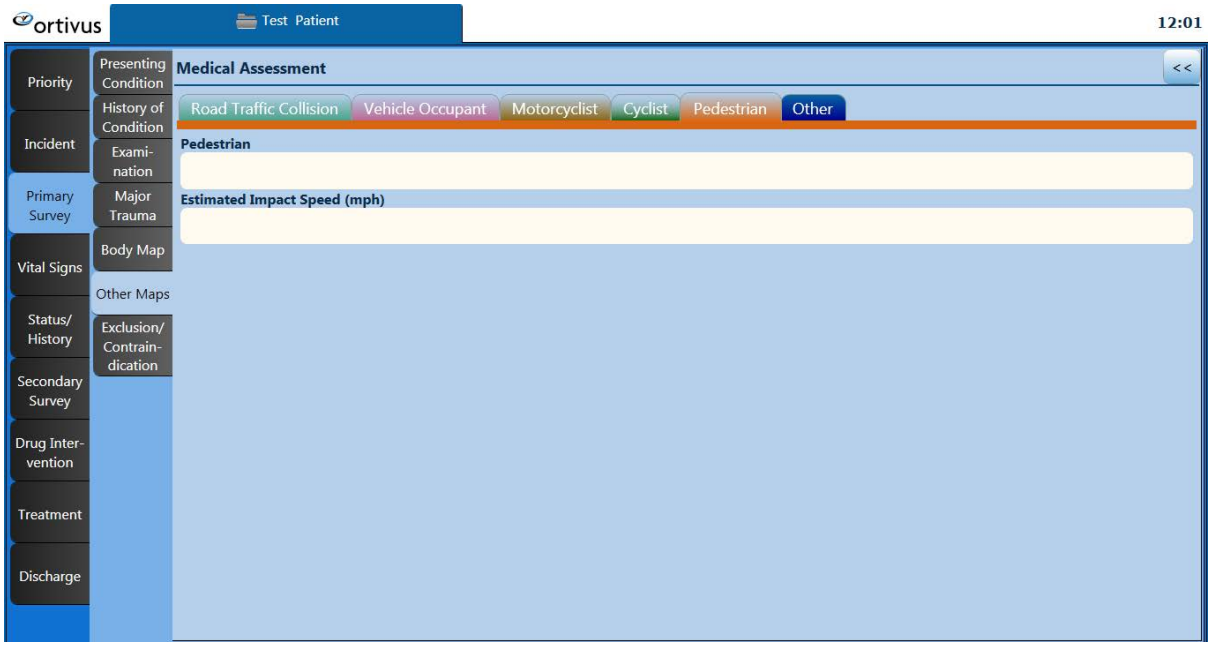
4.3.38 The **Motorcyclist** tab captures data relevant to road traffic collisions involving motor cycles. An additional free text field is available within the **Motorcyclist** field, which expands as text is entered. This supports the capture of additional information, such as the condition of the road, the weather at the time of incident, the use of appropriate leathers or other protective wear and the nature or mechanism of the collision etc..



4.3.39 The **Cyclist** tab captures data relevant to road traffic collisions involving bicycles. An additional free text field is available within the **Cyclist** field, which expands as text is entered. This supports the capture of additional information, such as the condition of the road, the weather at the time of incident and the nature or mechanism of the collision etc.

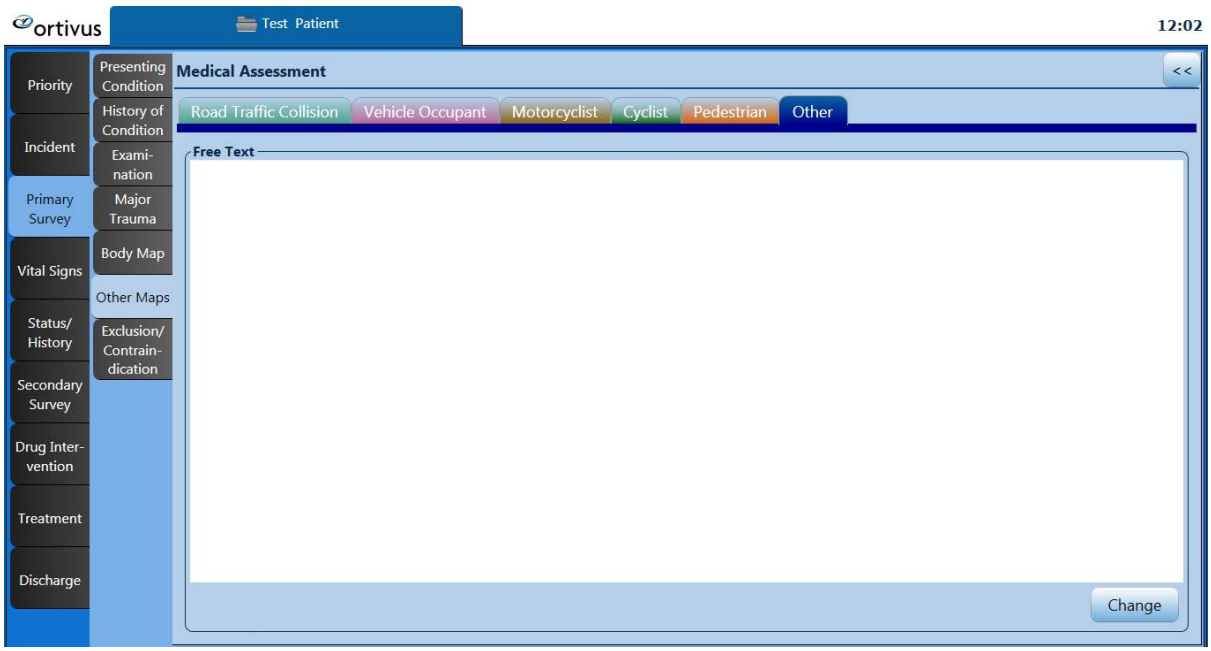


4.3.40 The **Pedestrian** tab captures data relevant to road traffic collisions involving pedestrians. An additional free text field is available within the **Pedestrian** field, which expands as text is entered. This supports the capture of additional information, such as the weather at the time of incident and the nature or mechanism of the collision etc.

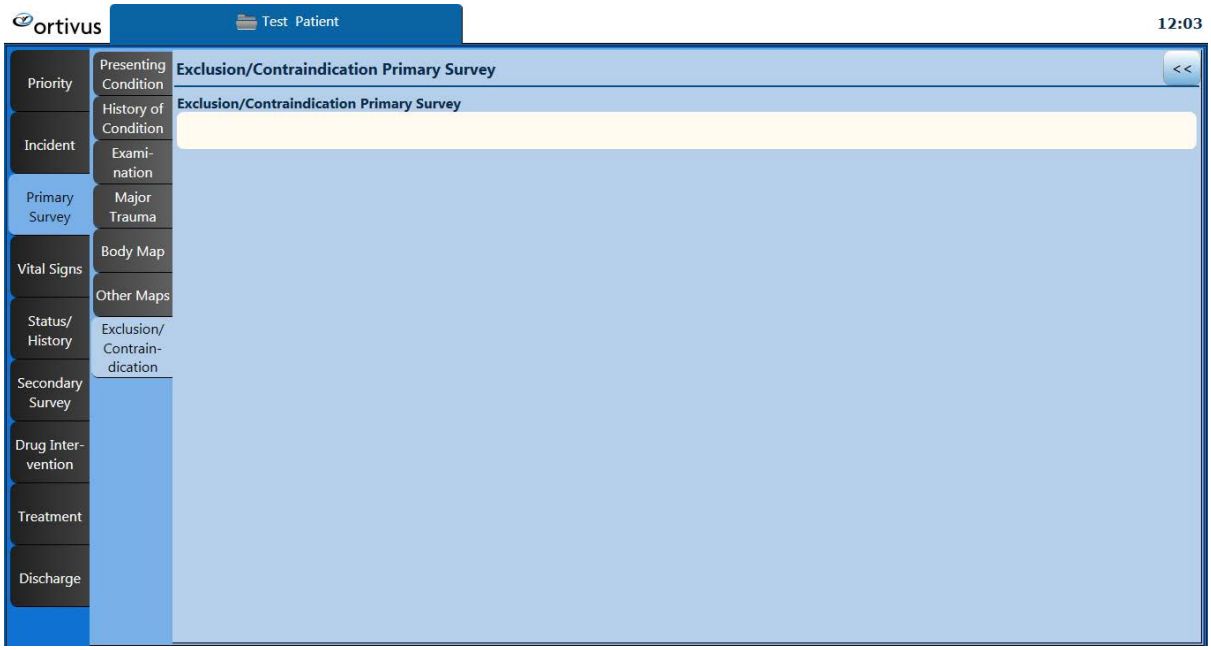


4.3.41 In order to allow the clinician to free hand draw a diagram or pictorial representation of the incident site or position of vehicles on the road etc, a large free text drawing box is provided.

4.3.42 The clinician clicks on Change and then uses the stylus provided to draw onto the screen the image they require..



4.3.43 A **Exclusion/Contra-indication** box is provided should the clinician wish to document any deviation from local or national guidelines at this point in the patient assessment. This is a free text format and the box expands as data is entered.



4.4 Primary Tab – Vital Signs

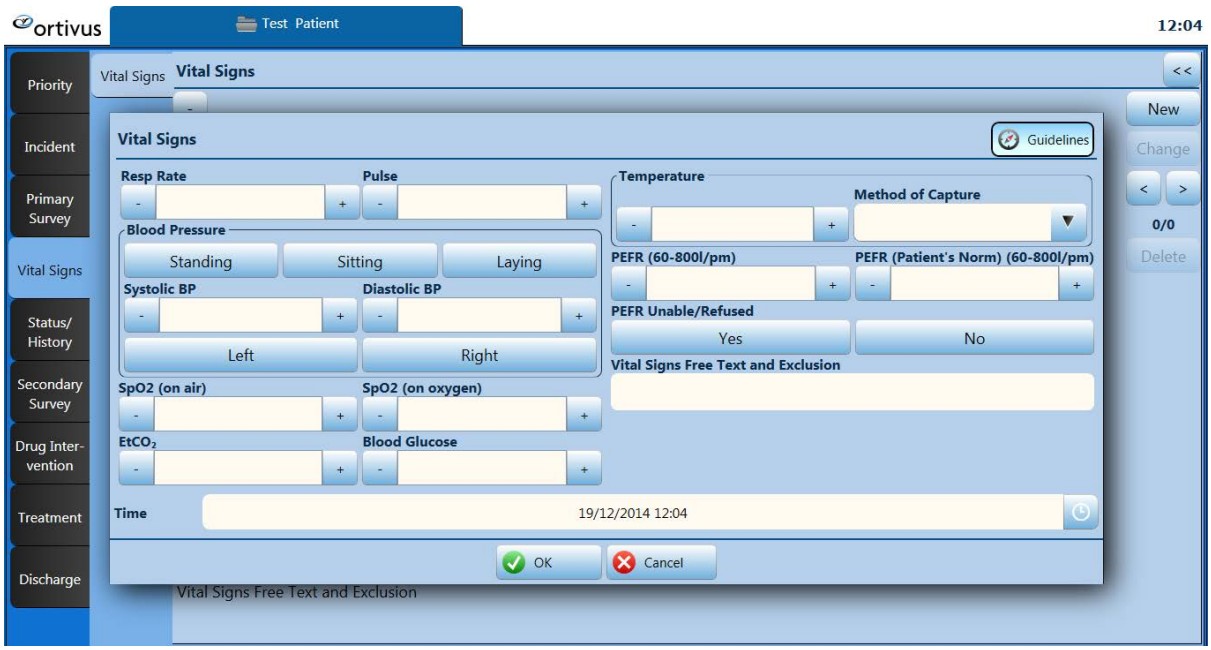
4.4.1 **Vital Signs** tab, allows the clinician to enter multiple patient vital signs, where connected to Mobimed Vital Signs Monitoring equipment these some fields will be auto-populated.

4.4.2 Additional information may be added to sets of observations or manual entry of observations when not using Mobimed Vital Signs Monitoring equipment may also be entered.

4.4.3 To enter a set of patient observations, the clinician clicks on the **New** tab. Should you wish to alter or change a set of observations, the clinician highlights the set of observations by clicking on them, then click **Change**. Additionally to delete a set of observations, the clinician highlights the set of observations by clicking on them, then click **Delete**.

4.4.4 Once a **New** set of observations is selected, the screen below will appear, many of the observations will have pre-set values, such as **Pulse** for example. If the clinician clicks on the pulse box, a value of 70 will appear, this can then be adjusted upwards or downwards as appropriate, by using the + or – buttons.

4.4.5 If a set of observations that would normally be required to support a clinical intervention or assessment, have not been taken, a **Vital Signs Free Text and Exclusion** field is available within the Vital Signs screen to capture the clinicians rationale.

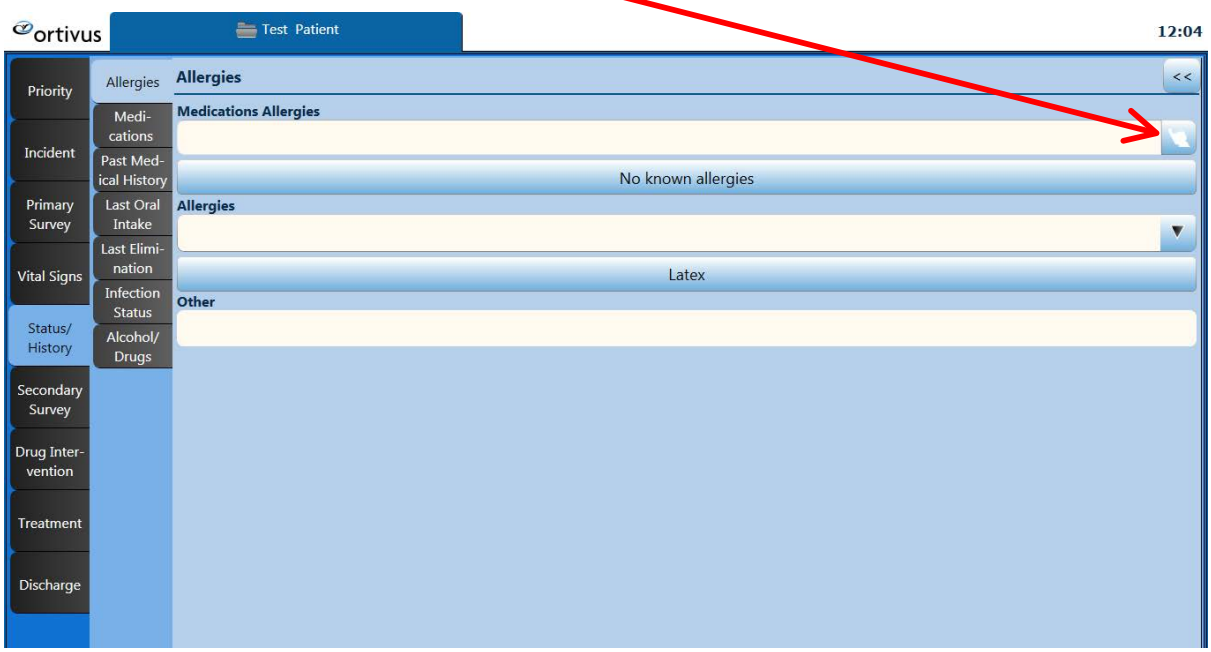


4.5 Primary Tab – Status/History

4.5.1 The **Status/History** of the patient tab enables the clinician to capture data that is relevant to the patients past medical history. This may include information that relates to any long term conditions and also any recent illness or injury that may be relevant to any care being considered by the clinician or those who may deliver any subsequent definitive care.

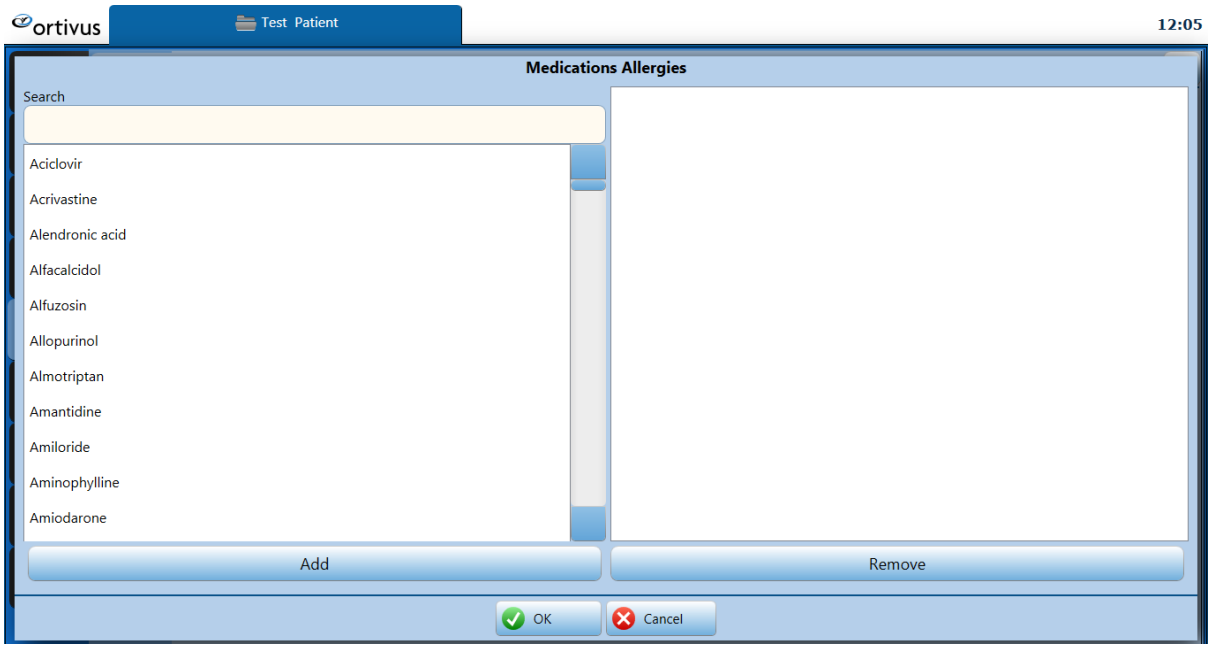
4.5.2 The **Allergies** tab enables the clinician to enter information relevant to medication allergies and also those relating to **Latex**. An additional drop down menu is available for allergies relating to plasters and foodstuffs. An additional free text field is available as **Other** which can be used to capture information relevant to any sensitivities that fall short of true allergy or other pertinent information of use for those who may be providing ongoing care.

4.5.3 In order to enter a medication allergy, the clinician first needs to click on the **white finger symbol**.



4.5.4 Once the white finger symbol is clicked the screen below is displayed. This enables the clinician to select medications that the patient is allergic to from an alphabetical list. An additional **Search** functionality is provided to support the clinician in finding the appropriate medication.

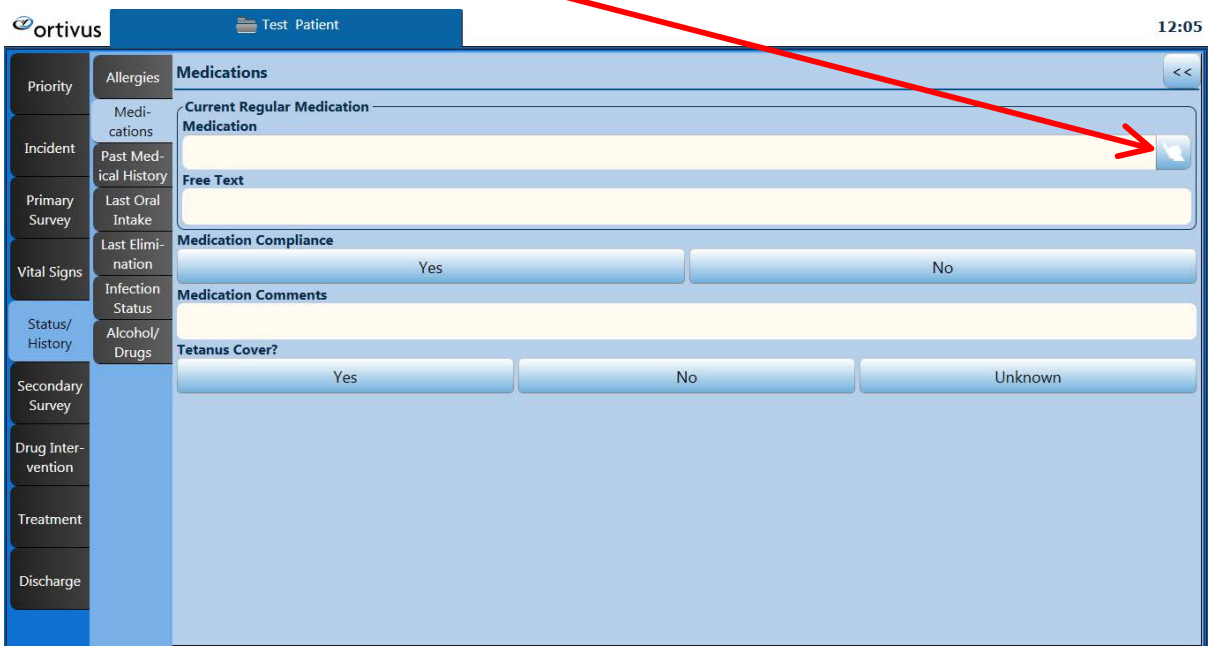
4.5.5 Once the medication is found, the clinician highlights the appropriate medication and clicks **Add**, this enters the medication as an allergy. Multiple selections can be made at this point. Once all medications to which the patient is allergic have been selected, the clinician clicks on **Ok**.



4.5.6 The **Medications** tab enables the clinician to enter information relevant to medication that the patient is currently prescribed. An additional Free Text Field is available which can be used to identify any medications which may have recently been added or are short term, such as recent antibiotics etc.

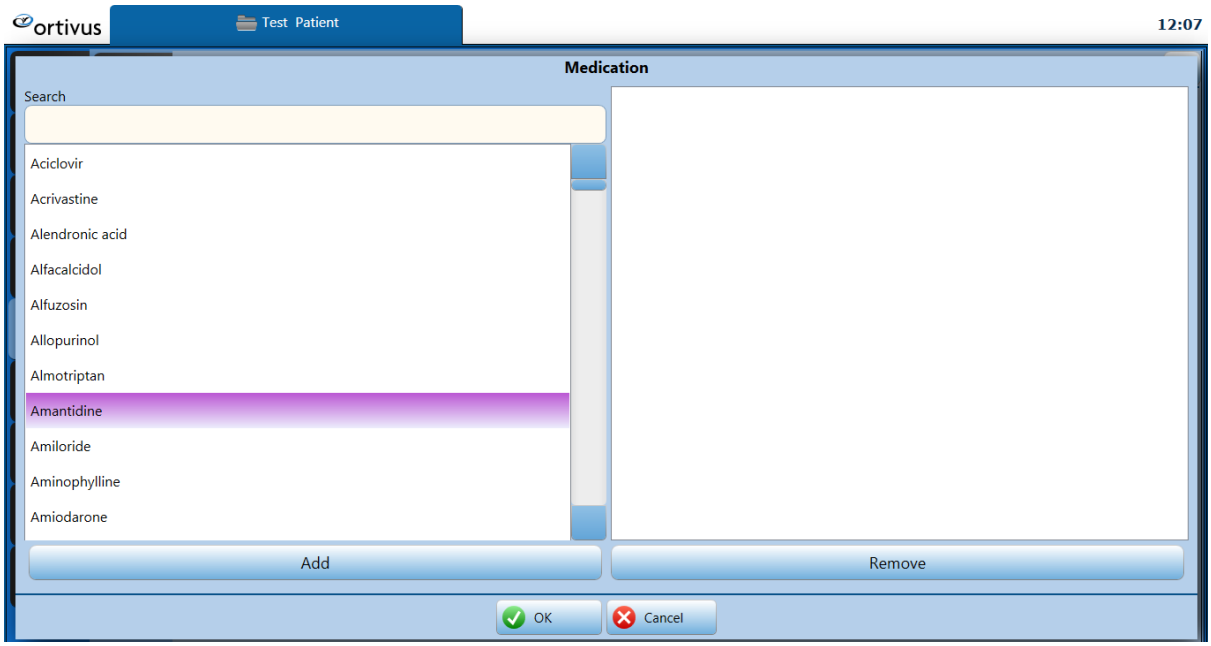
4.5.7 The **Medications** screen also allows the clinician to identify if the patient is currently non compliant with their medications and a **Medications Comments** free text field is available to expand on any current issues in relation to the patient medications, this may include details concerning any review or any gap in medication history.

4.5.8 In order to enter a current medication, the clinician first needs to click on the **white finger symbol**.



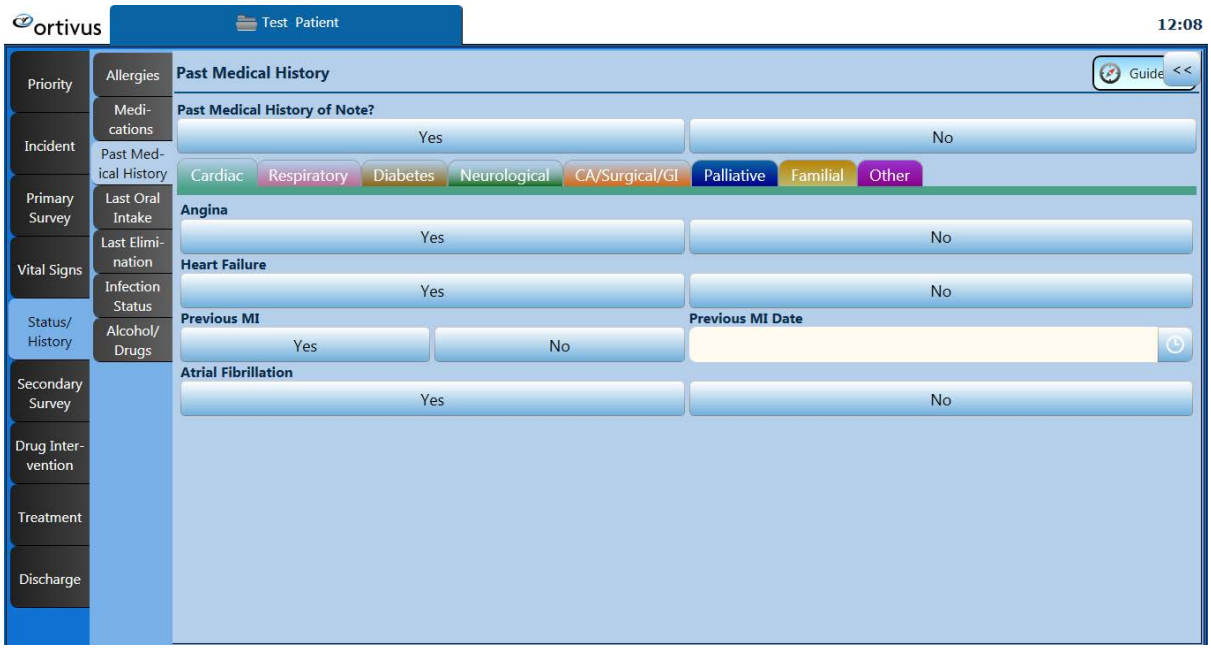
4.5.9 Once the white finger symbol is clicked the screen below is displayed. This enables the clinician to select medications that the patient is currently prescribed from an alphabetical list. An additional **Search** functionality is provided to support the clinician in finding the appropriate medication.

4.5.10 Once the medication is found, the clinician highlights the appropriate medication and clicks **Add**, this enters the medication. Multiple selections can be made at this point. Once all medications have been selected, the clinician clicks on **Ok**.

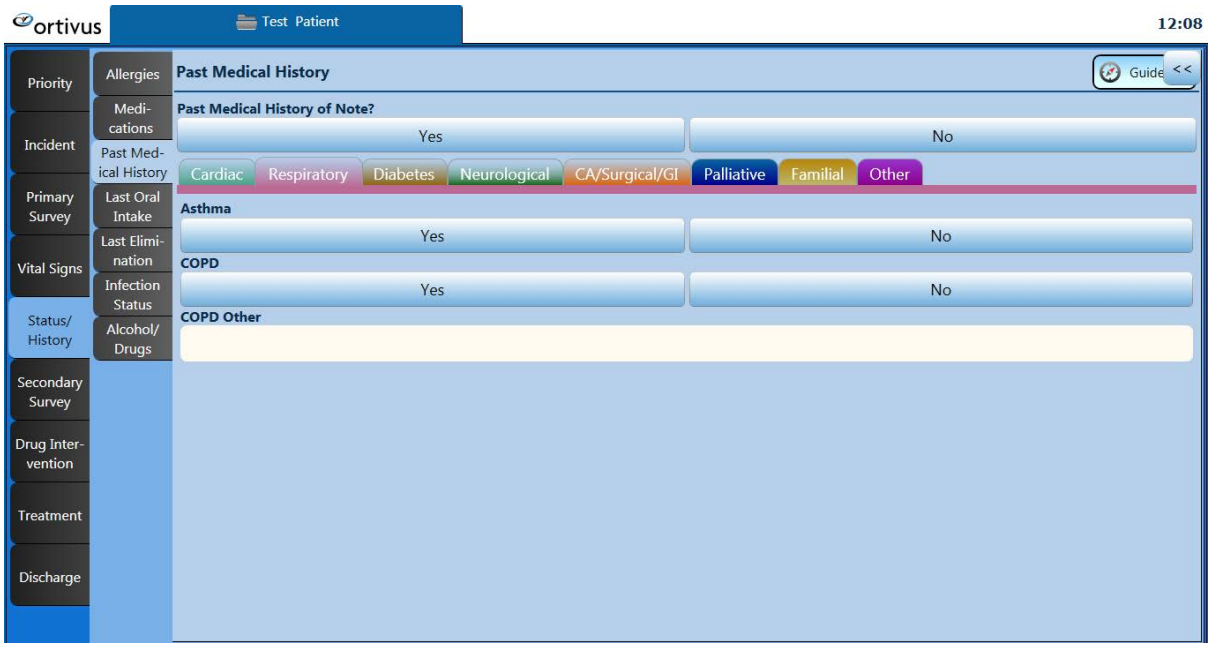


4.5.11 The **Past Medical History** tab is sub divided with a number of tertiary tabs, these identify specific medical history relevant to one clinical area. Additionally, should the patient have no Past Medical History of Note, the clinician can click on **No** as below.

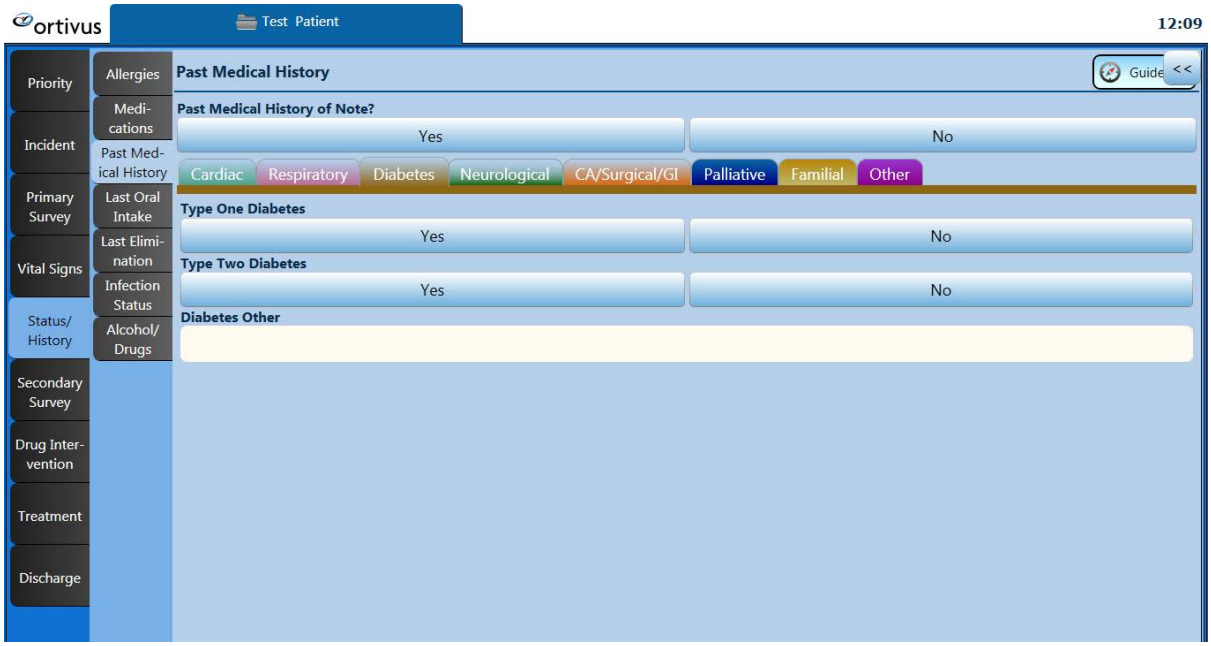
4.5.12 The **Past Medical History** tab opens with the **Cardiac** screen, this enables the clinician to identify any relevant history the patient may have impacting on their cardiac function. For example if the patient has previously suffered an MI (Myocardial Infarction) the clinician can enter **Yes** and then select a Month/Year within the **Previous MI Date** to identify the approximate date of the previous MI.



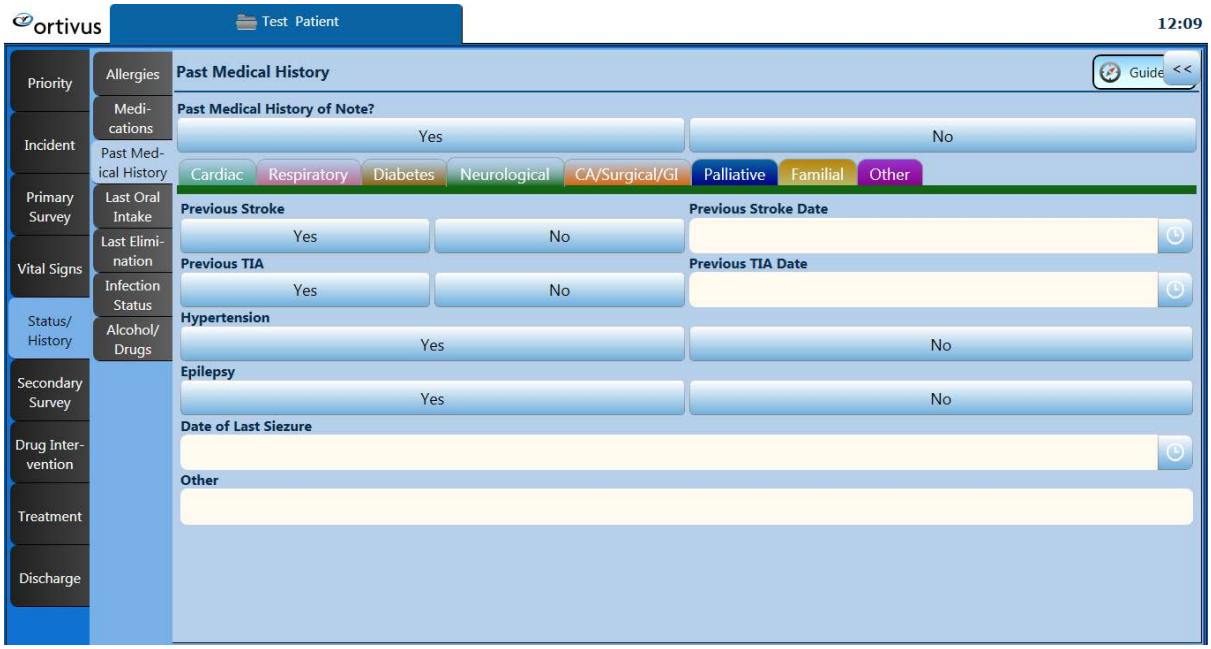
4.5.13 The **Respiratory** past medical history screen enables the clinician to confirm if the patient is asthmatic of suffers from COPD.



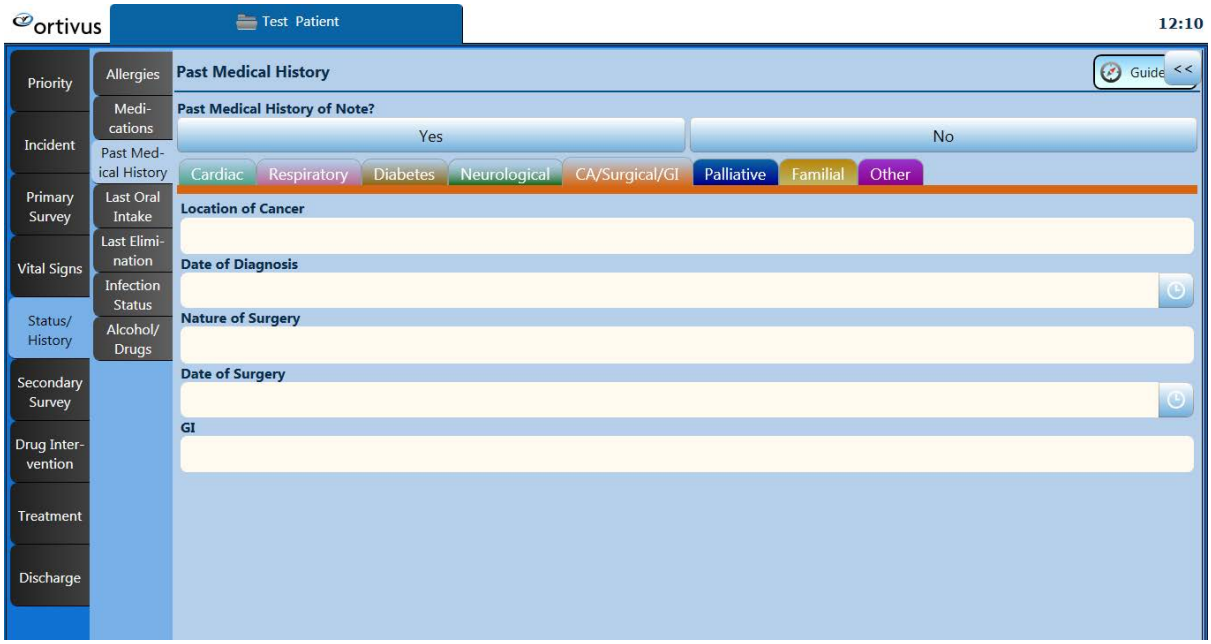
4.5.14 The **Diabetic** past medical history screen enables the clinician to confirm if the patient is either Type One or Type Two diabetic, it also provides a free text option should the clinician wish to enter additional information relevant to the patients diabetes.



4.5.14 The **Neurological** past medical history screen enables the clinician to confirm whether the patient has suffered a previous TIA or Stroke and if so to identify the approximate date. It also allows the clinician to enter additional information relevant to the patients hypertensive or epileptic history.

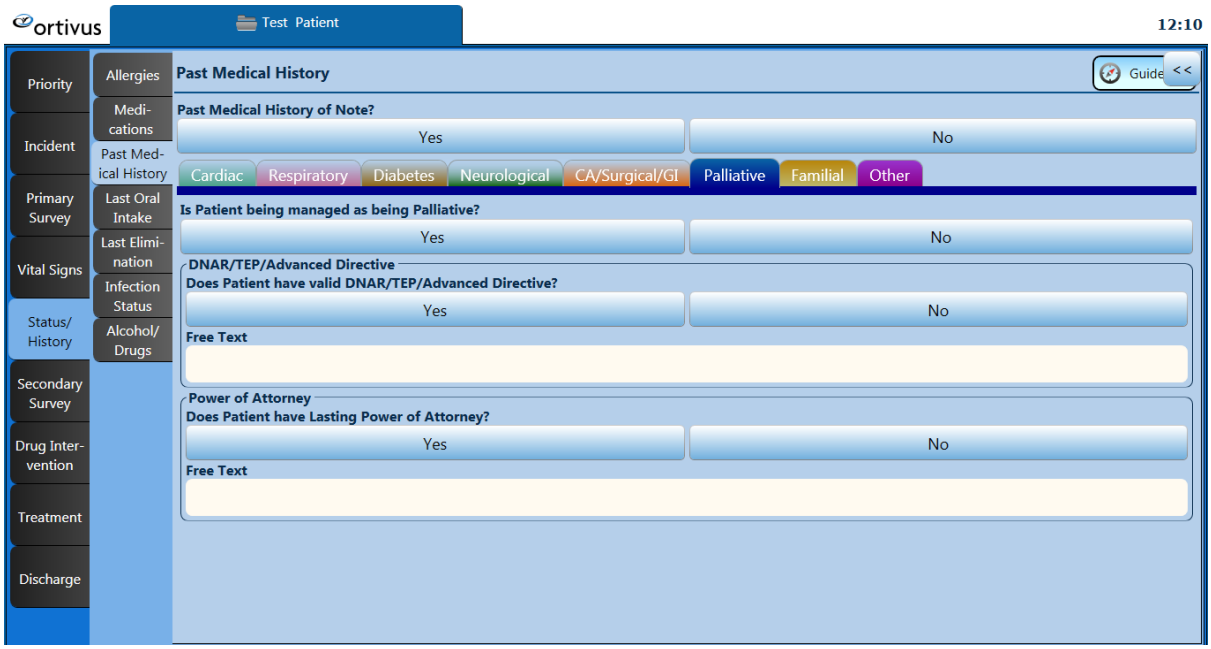


4.5.15 The **CA/Surgical/GI** past medical history screen enables the clinician to confirm whether the patient has a cancer diagnosis and if so to identify the approximate date of that diagnosis. It also allows the clinician to enter additional information relevant to the patients relevant **Surgical** history or an **GI** (Gastro-intestinal) history of relevance.

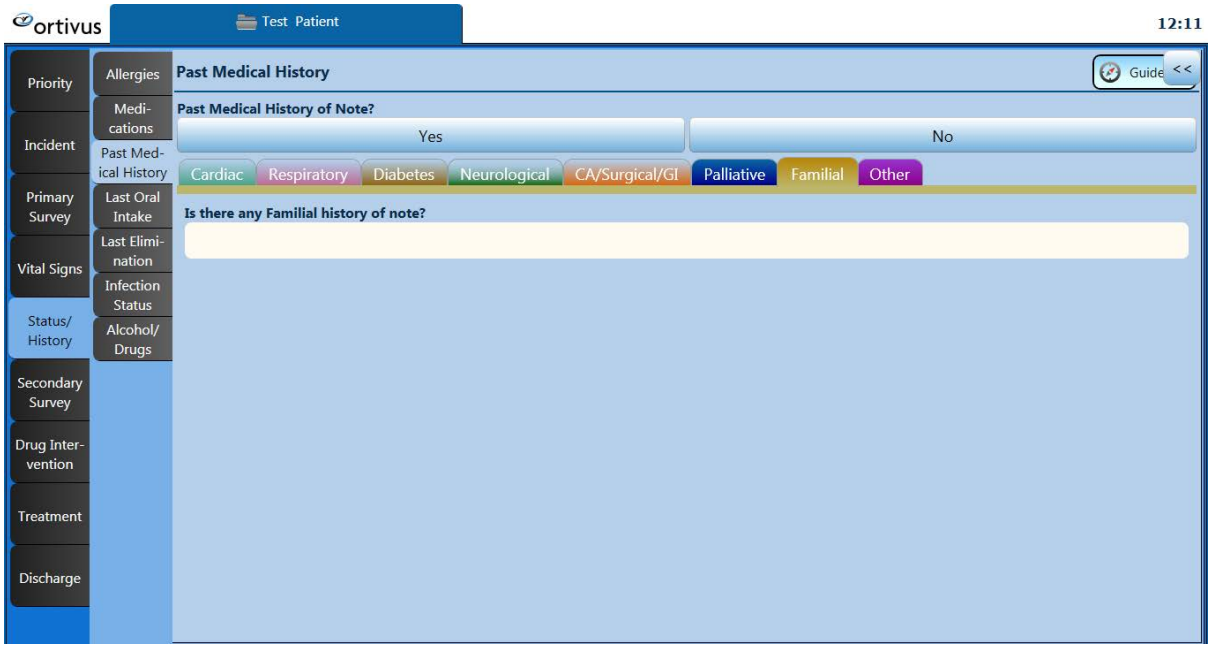


4.5.16 The **Palliative** past medical history screen enables the clinician to confirm whether the patient is being actively managed as end of life. It also allows the clinician to enter additional information in free text format relevant to any **DNAR** (Do Not Attempt Resuscitate Order), **TEP** (Treatment Escalation Plan) or **Advanced Directive**.

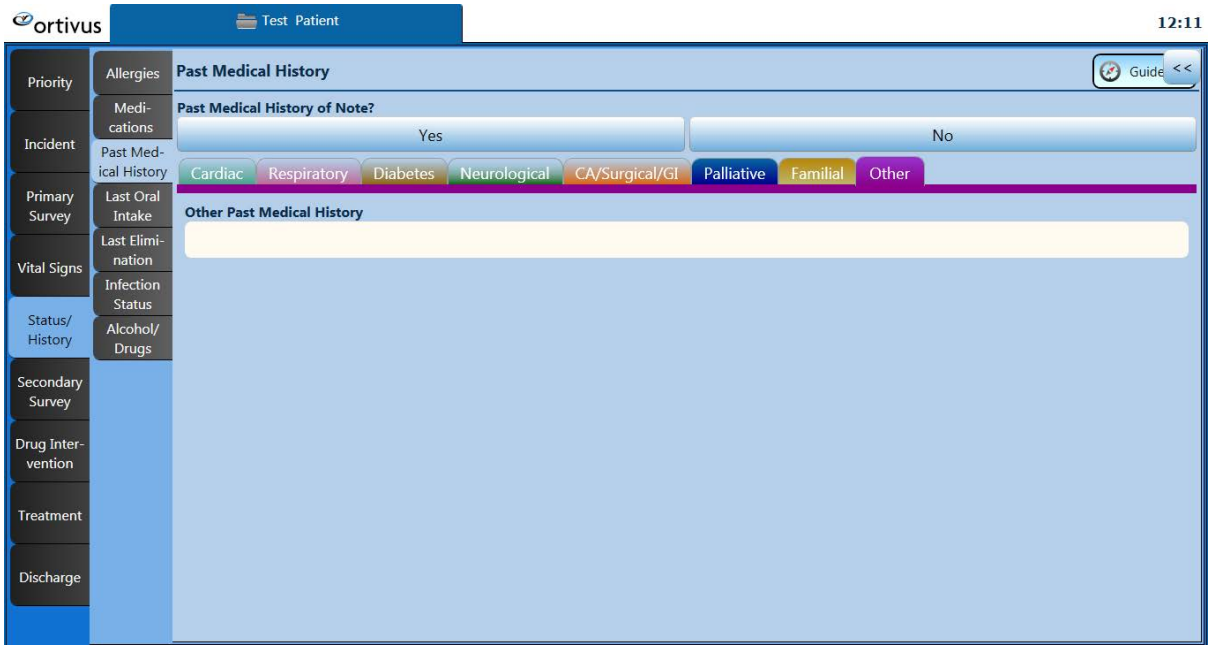
4.5.17 The **Palliative** past medical history screen also enables the clinician to confirm whether the patient has a **Lasting Power of Attorney**, consideration should be given to whether the patients Lasting Power of attorney has power over financial matters or in addition has power to make decisions for those relating to health matters.



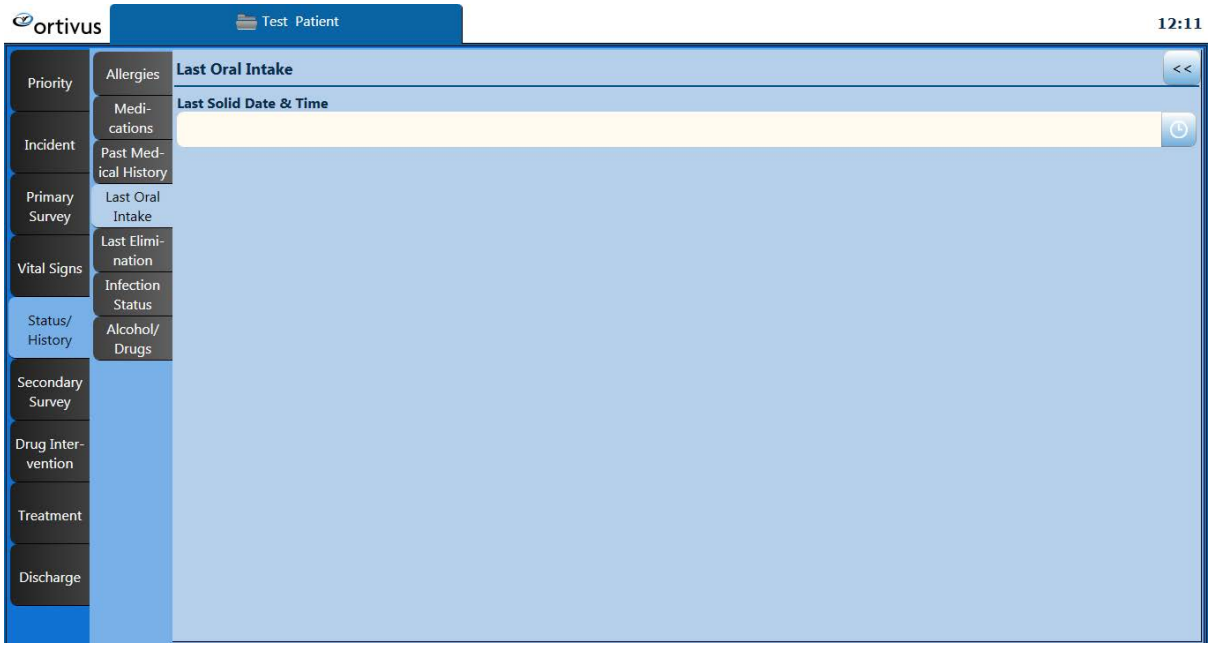
4.5.18 The **Familial** past medical history screen, has a single free text field which expands as the clinician types. This allows the clinician to enter information relating to the patients familial history. This could include details of parents cardiac history or siblings cancer diagnosis etc.



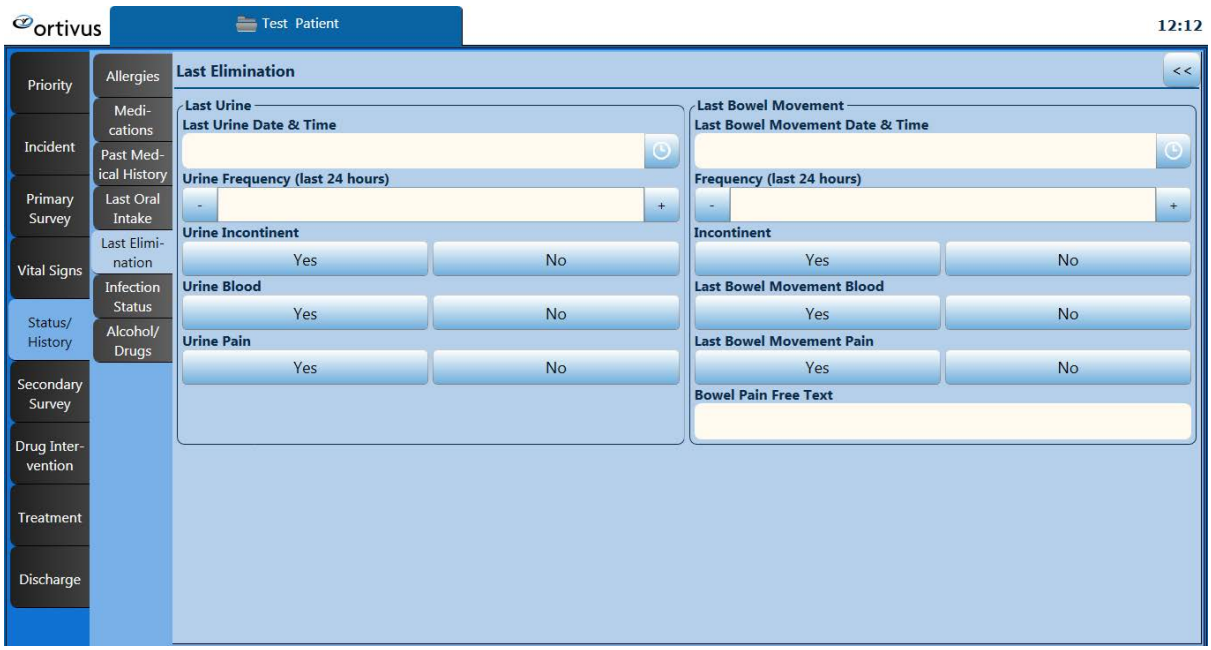
4.5.19 The **Other** past medical history screen, has a single free text field which expands as the clinician types. This allows the clinician to enter information relating to any other information regarding a past medical complaint or recent illness or injury.



4.5.20 The **Last Oral Intake** past medical history screen, has a single free text field which expands as the clinician types. This allows the clinician to enter information relating to the date and time of the last solid food eaten. This may be relevant if the patient may require surgical intervention or is suffering from hypoglycaemia or syncope.

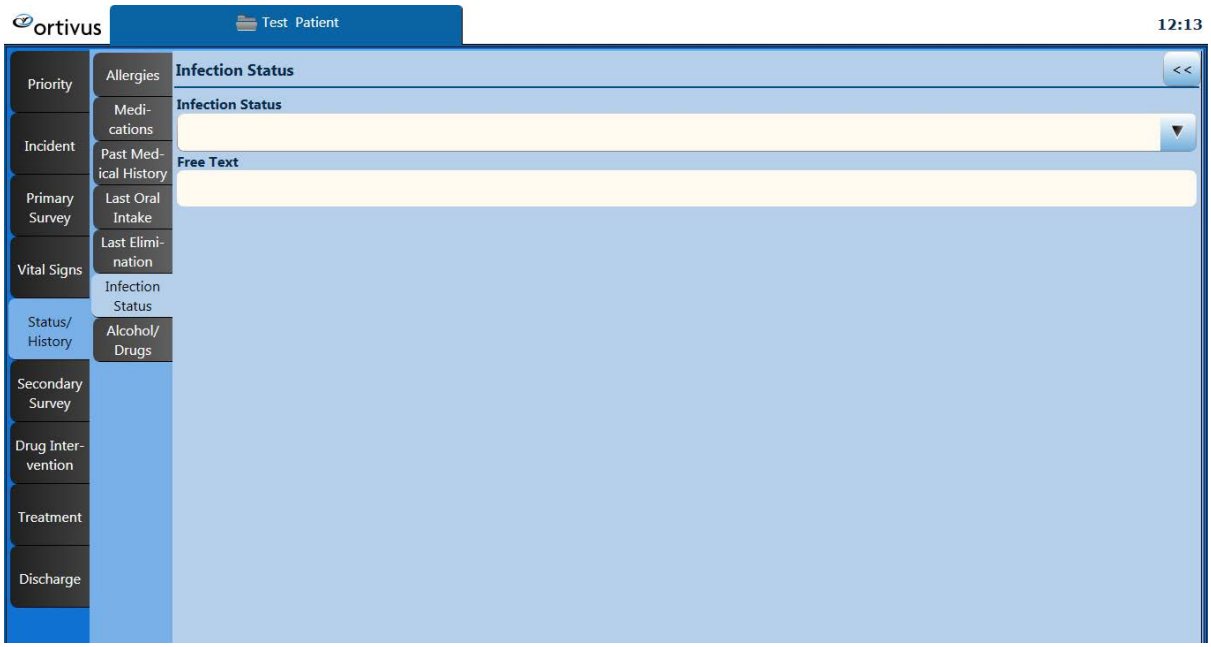


4.5.21 The **Last Elimination** past medical history screen, has a data fields relating the patients last urination and bowel movement. This allows the clinician to enter information relating to the date and time of the last elimination and additional information such as the presence of blood and/or pain. This may be relevant if the patient has an acute abdominal pain or is suffering from urinary retention or constipation.

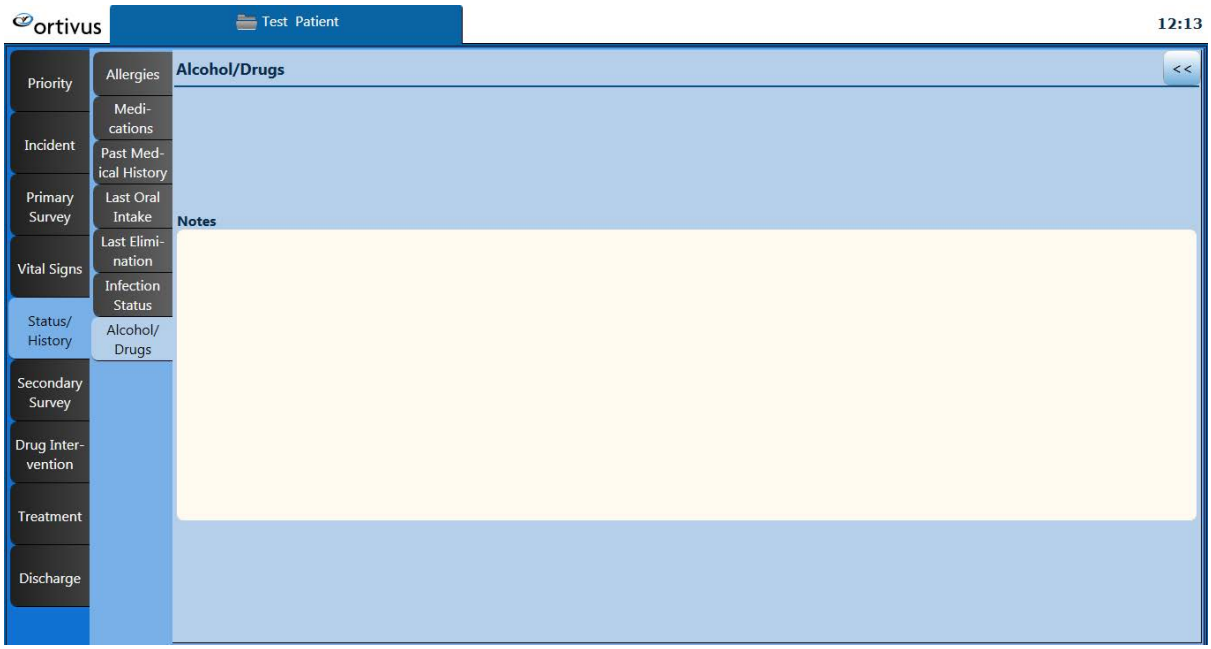


4.5.22 The **Infection Status** provides a drop down list of common infectious diseases which can be used if the patient has a confirmed infection. This includes C Difficile and Norovirus. This would be essential information for any receiving hospital.

4.5.23 The clinician is also provided with a free text field which expands as the clinician types to capture any further information which may be relevant. This could include issues such as scabies etc.



4.5.22 The **Alcohol/Drugs screen** provides a free text field which expands as the clinician types to capture any further information which may be relevant in relation to alcohol and/or recreational drug use.

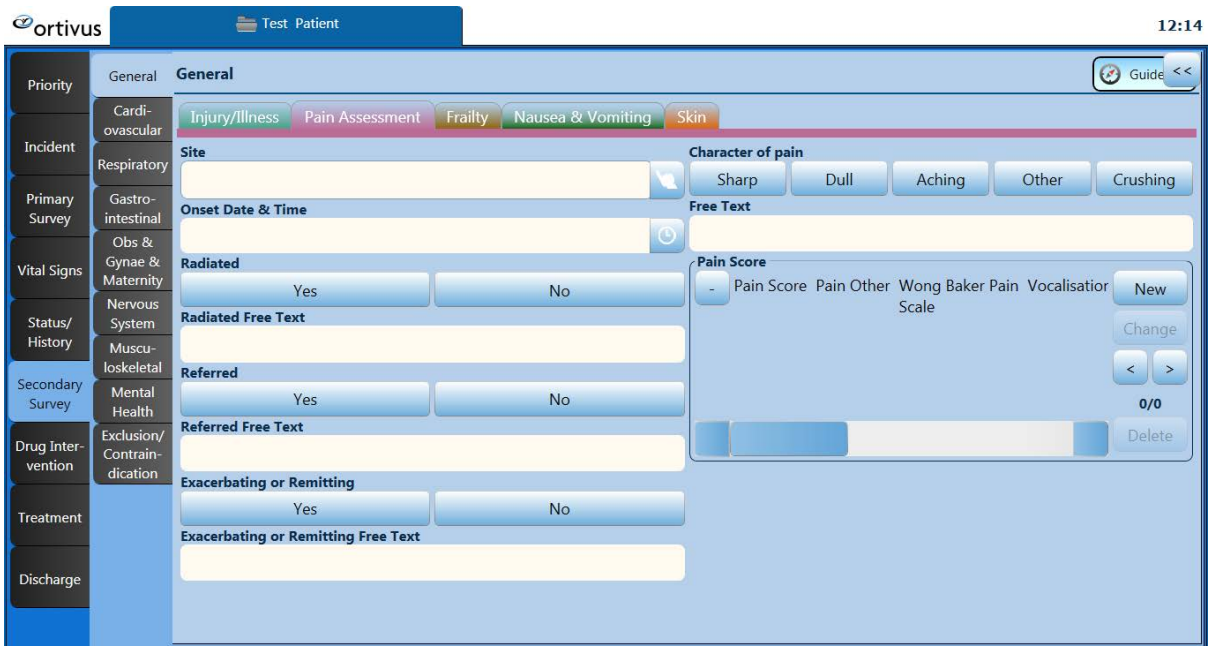


4.6 Primary Tab – Secondary Survey

4.6.1 General

4.6.2 The General screen has a number of tertiary tabs, which allow the clinician to enter information that relates to the more detailed assessment that is conducted once any life threatening observations have been concluded.

4.6.3 The Pain Assessment screen allows the clinician to enter a detailed assessment of the patients pain, in terms of location, whether it is referred to a separate body area, whether it radiates from the main location to a point distal to that centre and whether there are any factors which help the patient relieve the pain or conversely anything that makes it worse.

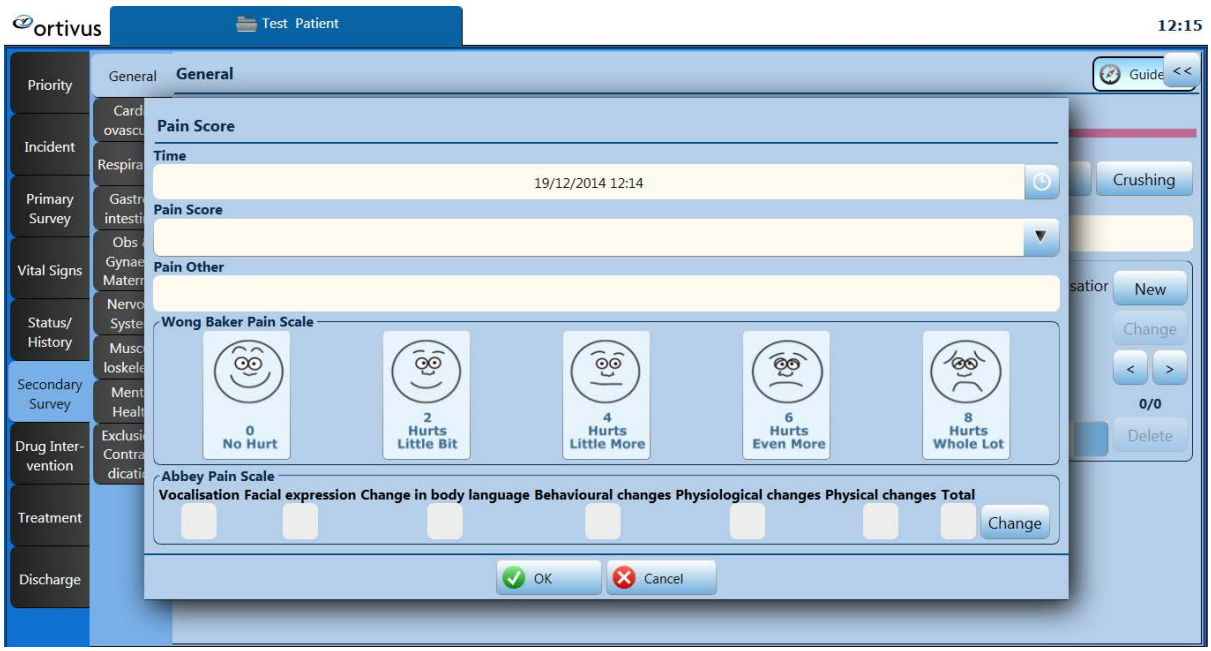


4.6.4 In order to enter site of the patient's pain, the clinician first needs to click on the **white finger symbol**. This then opens the drop down menu below, from which the clinician can select multiple sites.

4.6.5 An evaluation of pain is an essential component of the patient assessment. In order to better capture the assessment across a range of patients the clinician is provided with a detailed assessment screen that is accessed by clicking the **New** button within **Pain Score**.

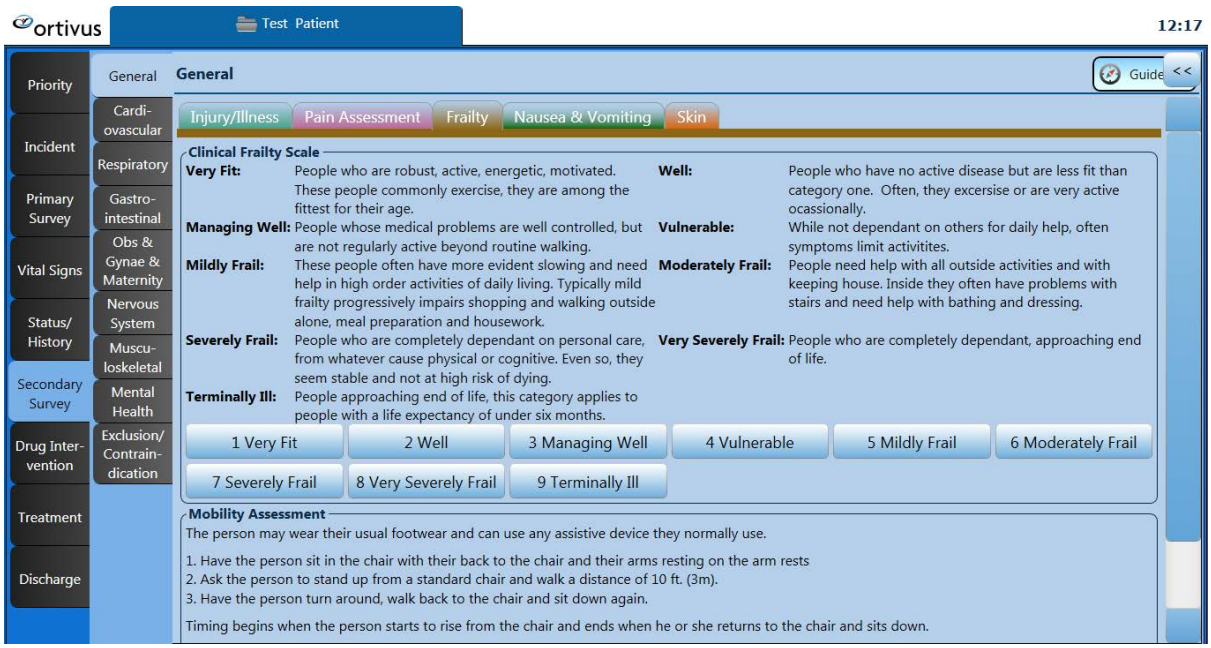
4.6.6 A simple 0 to 10 pain score can be entered using the drop down button in Pain Score. Alternatively for paediatrics the **Wong Baker Pain Scale** can be used to determine a child's pain score.

4.6.7 Additionally the **Abbey Pain Scale**, a tool for assessing the pain of a patient who is unable to express this, can be accessed by clicking the **Change** button within the **Abbey Pain Scale**. This is useful in particular for assessing the pain of patients with dementia. The clinician reviews the questions, selecting the appropriate answers. The tool will then display the appropriate level of pain based on the answers provided.



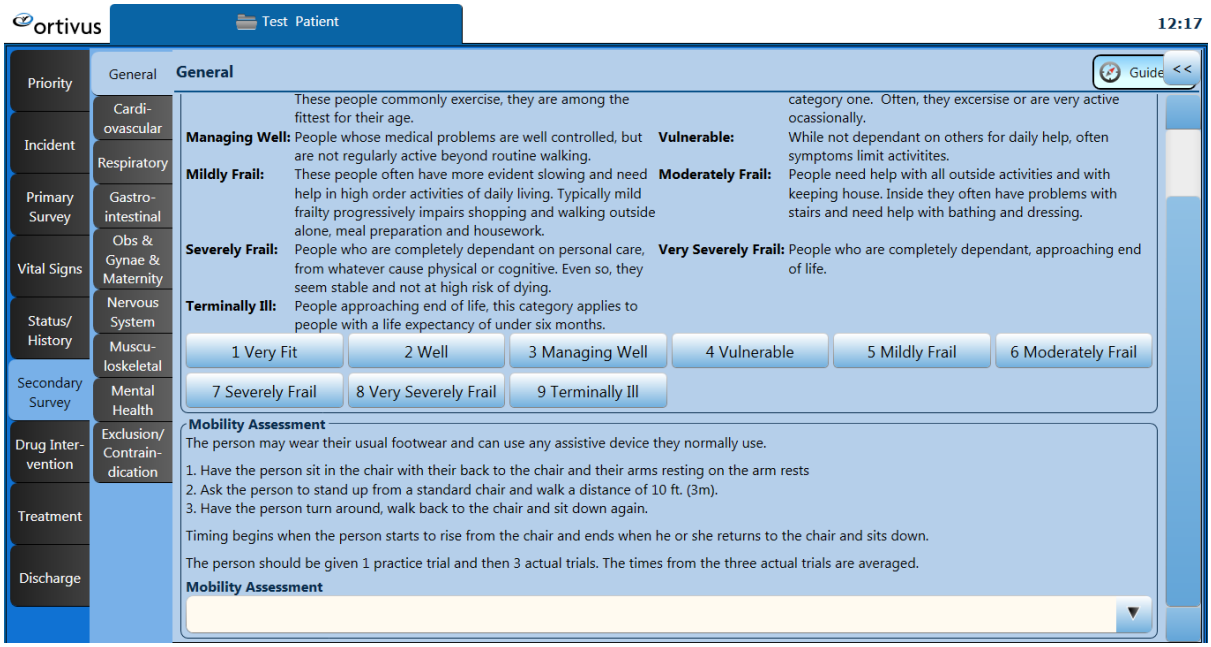
4.6.8 The term “Frail” is often used without an agreed definition and is therefore subjective and open to personal interpretation. The **Rockwood Frailty Scale** allows the clinician to select the description that best fits the patient they are assessing. This then provides a standardised criteria and definition of frailty.

4.6.9 Thee clinician simply reads each definition and selects the one that most closely matches the description of the patient.

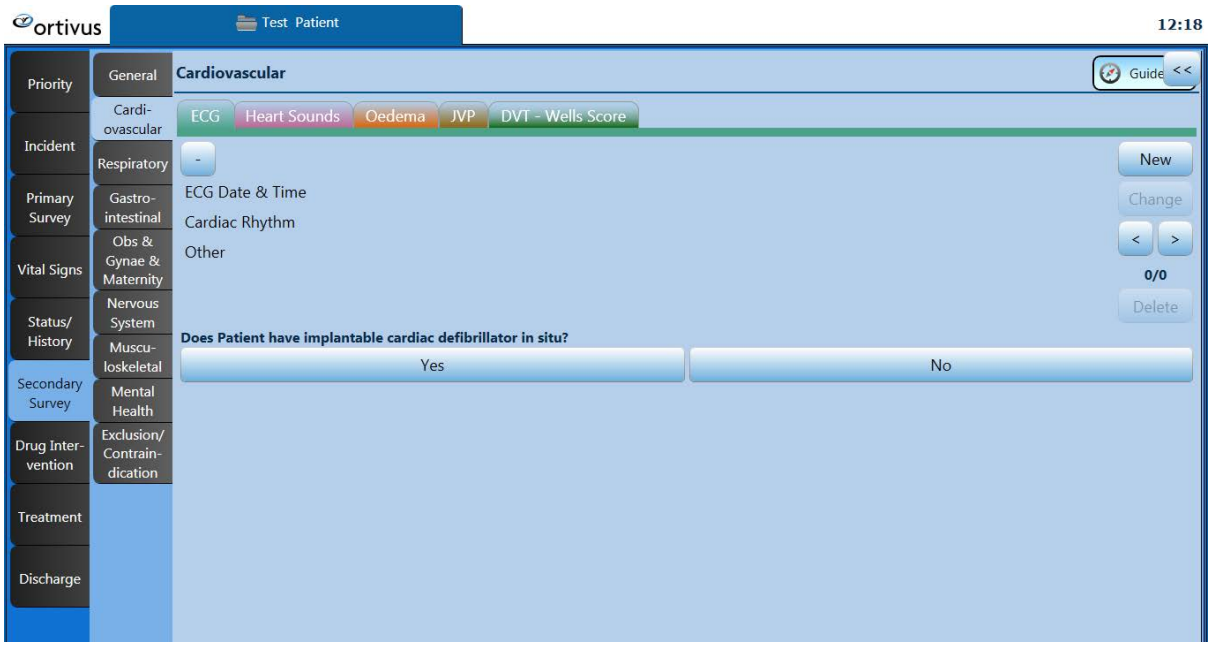


4.6.10 The clinician may also wish to record a **Mobility Assessment** for the patient, this would in particular support the determination that a patient is safe to discharge at home and able to mobilise to a sufficient degree to self care and access bathroom facilities and kitchen etc.

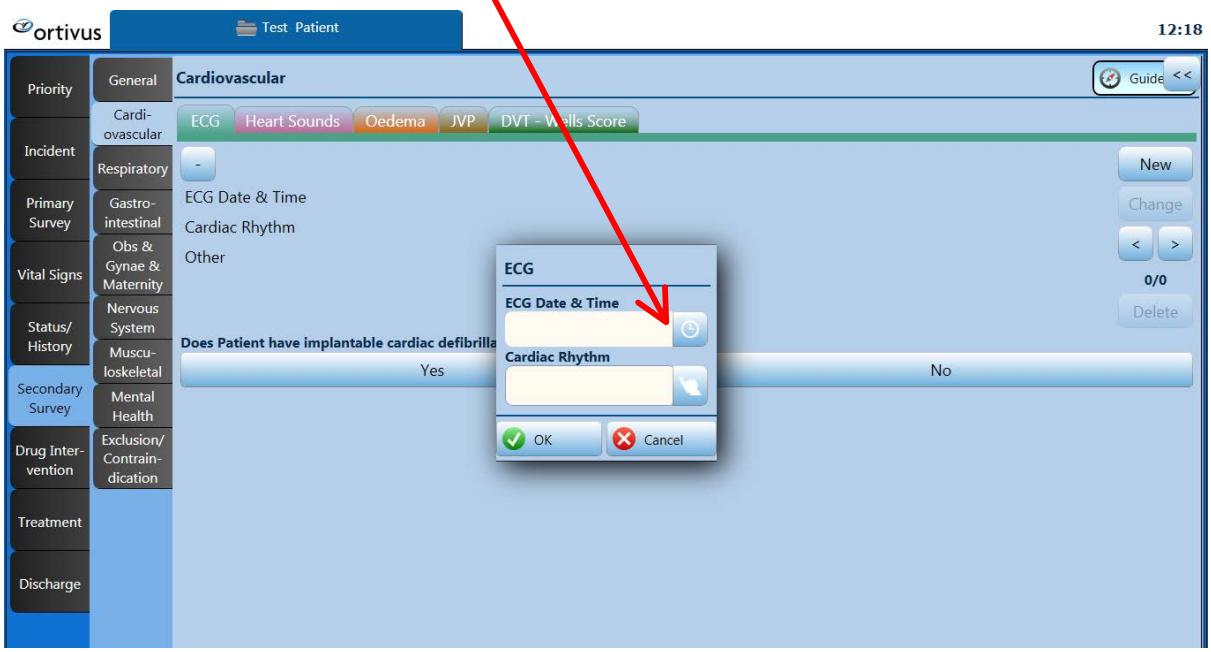
4.6.11 In order to conduct the assessment, the clinician follows the on screen instructions, having the patient stand and mobilise for ten feet whilst timing how long this takes.



4.6.12 The **Cardiovascular** screen has a number of tertiary tabs that allow the clinician to document a thorough assessment of the patients cardiovascular system.

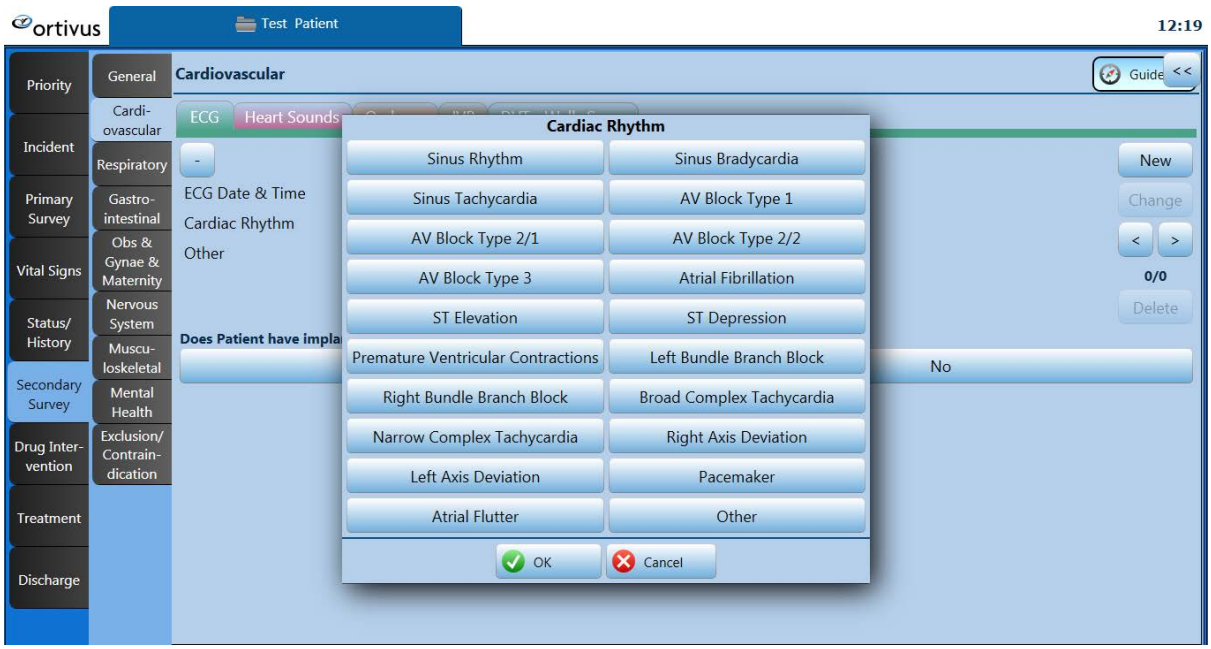


4.6.13 The first tab **ECG** within Cardiovascular allows the clinician to document the patients ECG, the clinician clicks on the New button for a new assessment and then selects the **white finger symbol** to open a drop down list of heart rhythms.

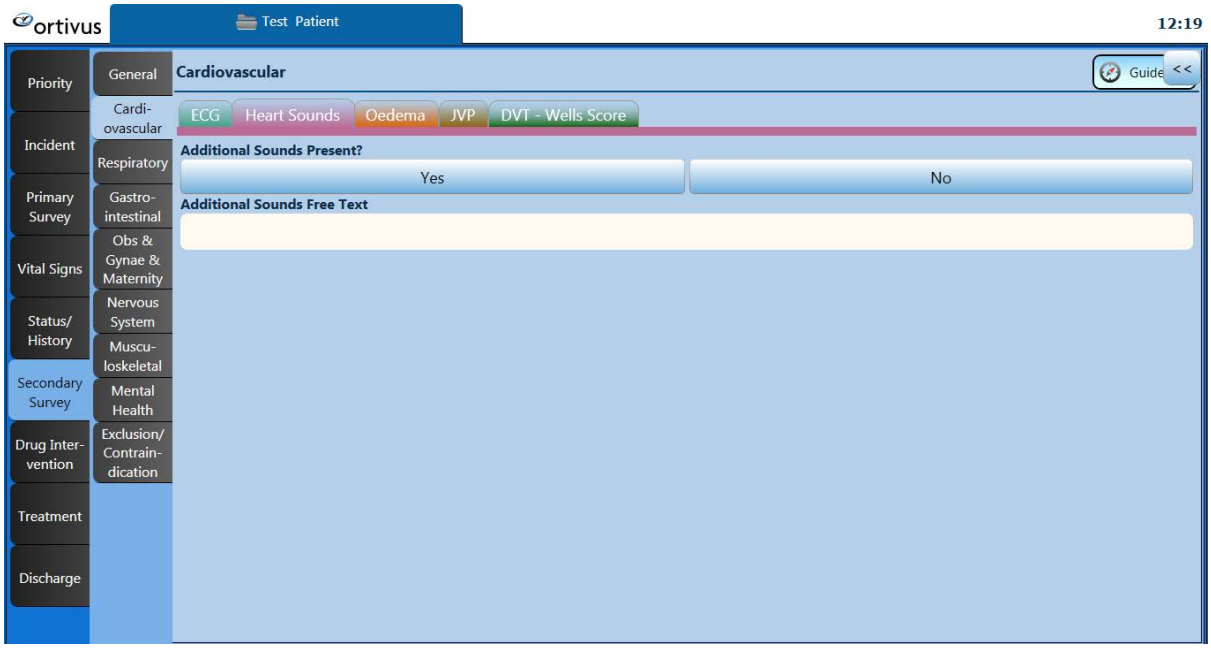


4.6.14 The drop down list of rhythms enables the clinician to select multiple fields, for example a patient with pacemaker who has a sinus rhythm.

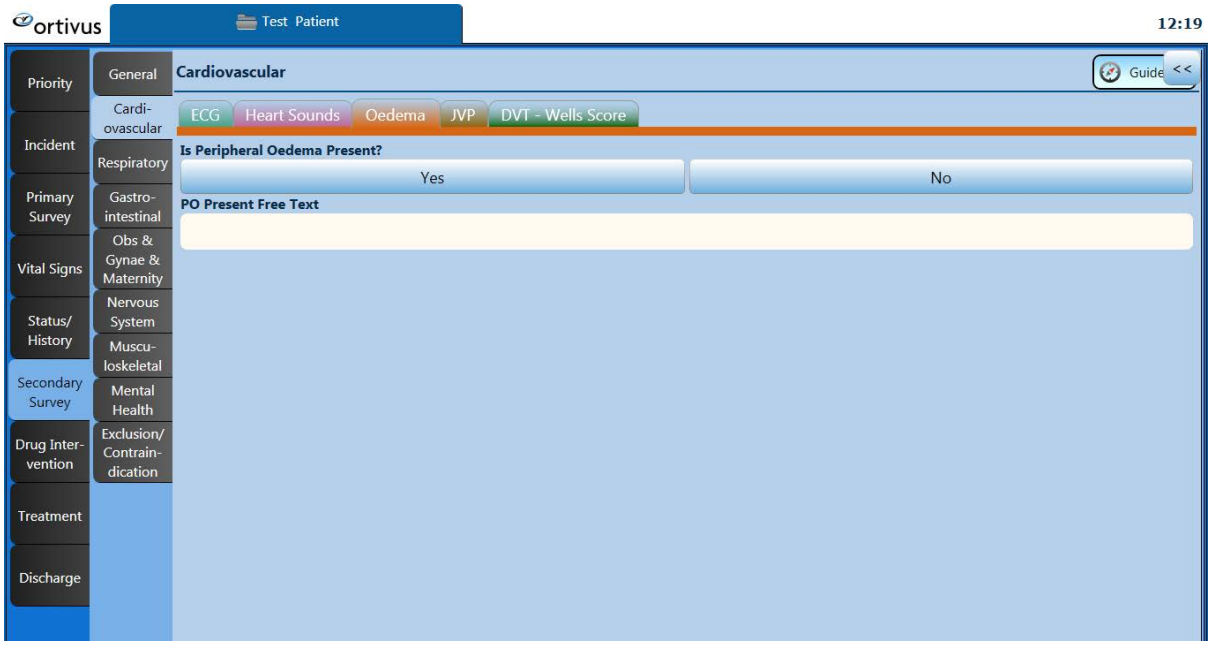
4.6.15 The drop down list also incorporates an **Other** field, when selected the date/time, rhythm field shown in 5.6.13 will also incorporate a free text field to capture details of the clinician assessment.



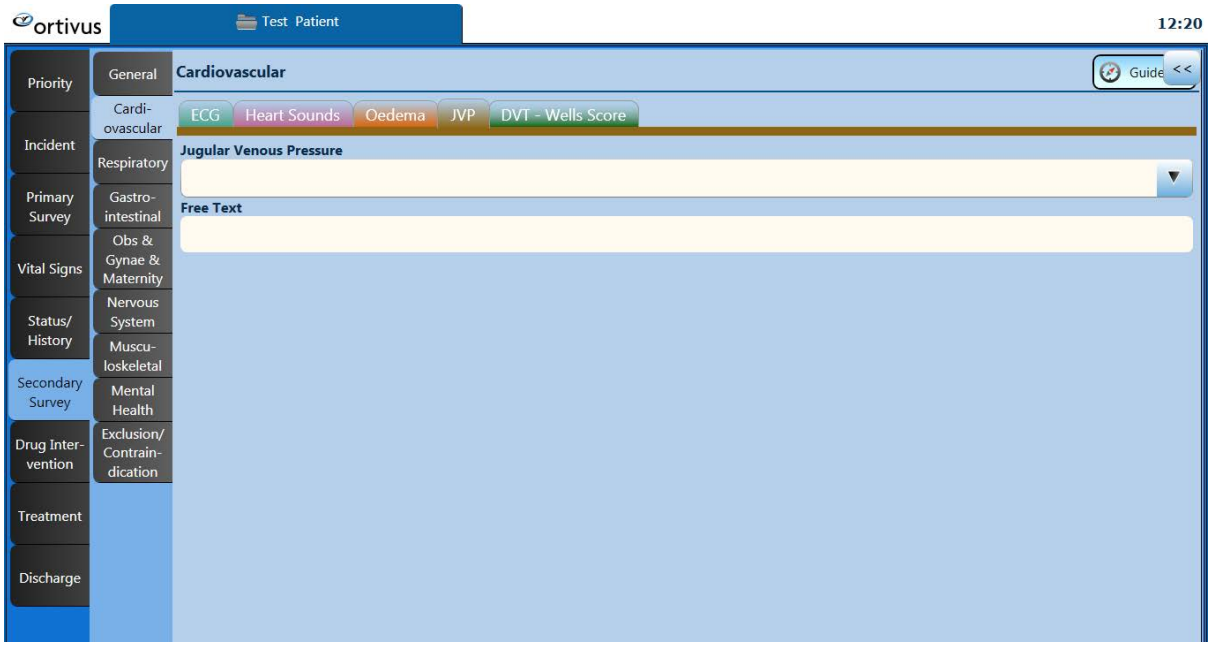
4.6.16 Should the clinician be competent in the assessment of **Heart Sounds**, this assessment can be recorded within the fields below. A simple Yes, No can be used to identify if any additional sounds are present and a free text format field for the recording of specific details.



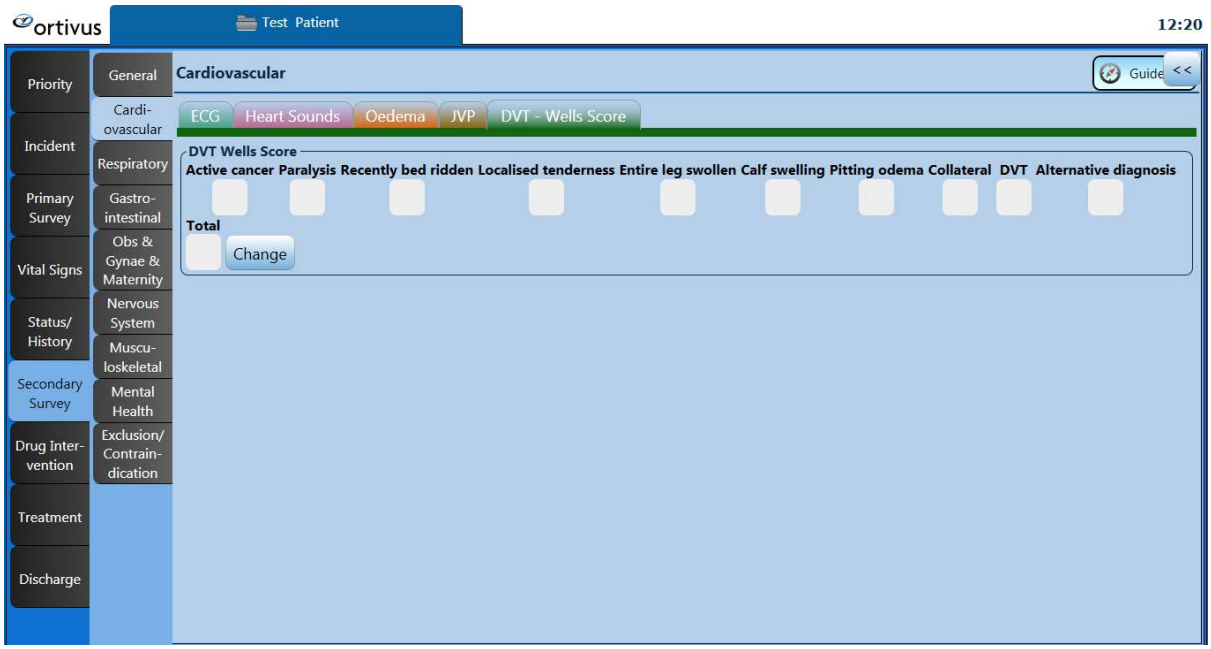
4.6.17 Should the clinician wish to record an assessment of **Peripheral Oedema**, this assessment can be recorded within the fields below. A simple Yes, No can be used to identify if any Oedema is present and a free text format field for the recording of specific details.



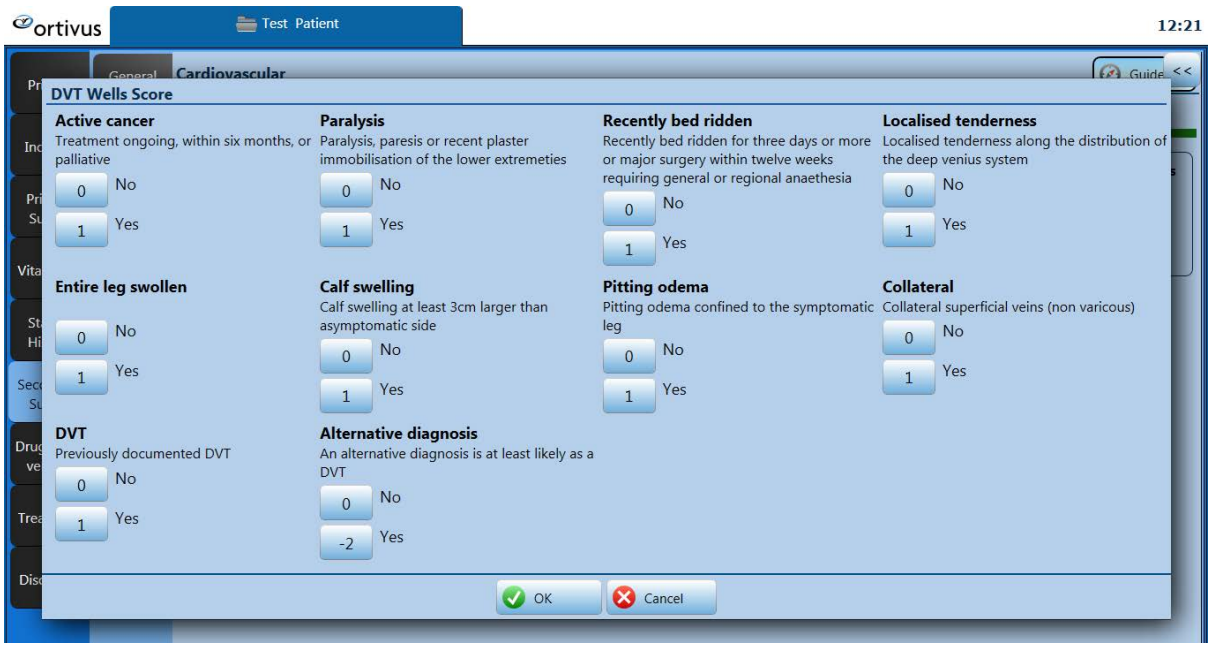
4.6.18 Should the clinician wish to record an assessment of **Jugular Venous Pressure**, this assessment can be recorded within the fields below. A drop down list can be accessed to identify if the JVP is raised, normal or lowered, and a free text format field for the recording of specific details.



4.6.19 The **Wells Score** for Deep Vein Thrombosis is a clinical support tool to assist in the determination of the likelihood of the patient suffering a DVT. In order to access the tool the clinician simply clicks **Change**.



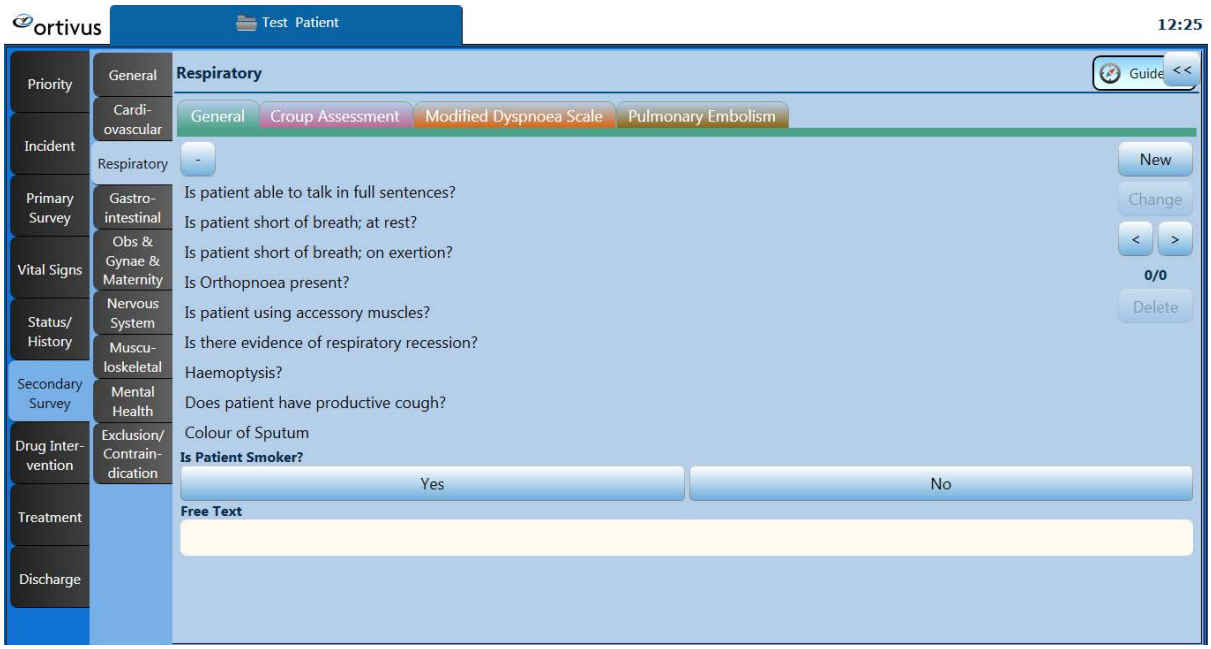
4.6.20 Once the clinician clicks on **Change** the following checklist appears, the clinician then answers the questions as presented. Once all ten questions have been answered, the clinician clicks **OK** and the screen will identify the likelihood of a DVT being present. The clinician must then make a determination based on this and other findings to provide a clinical outcome and determine the most appropriate course of action.



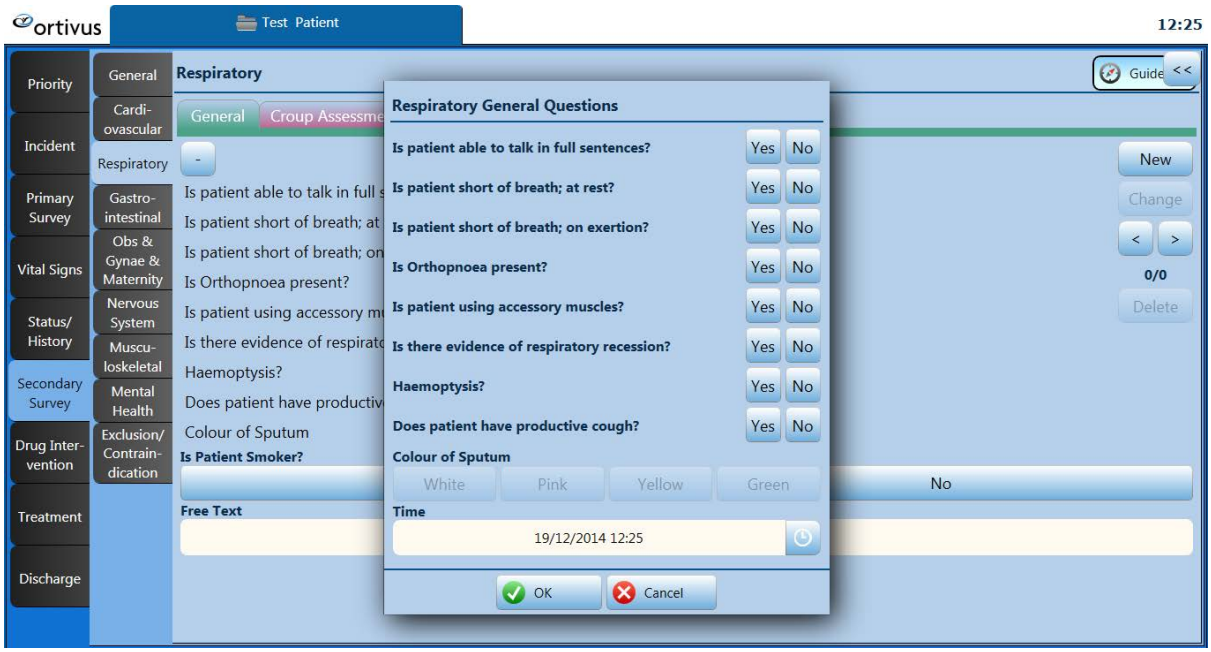
4.6.21 The **Respiratory** screens allow the clinician to undertake a thorough assessment of the patient's respiratory function.

4.6.22 The first tab captures details of the **General** assessment, this may be required to be undertaken on more than one occasion, for example prior to treatment and after treatment. The clinician simply clicks on New to undertake a new general assessment.

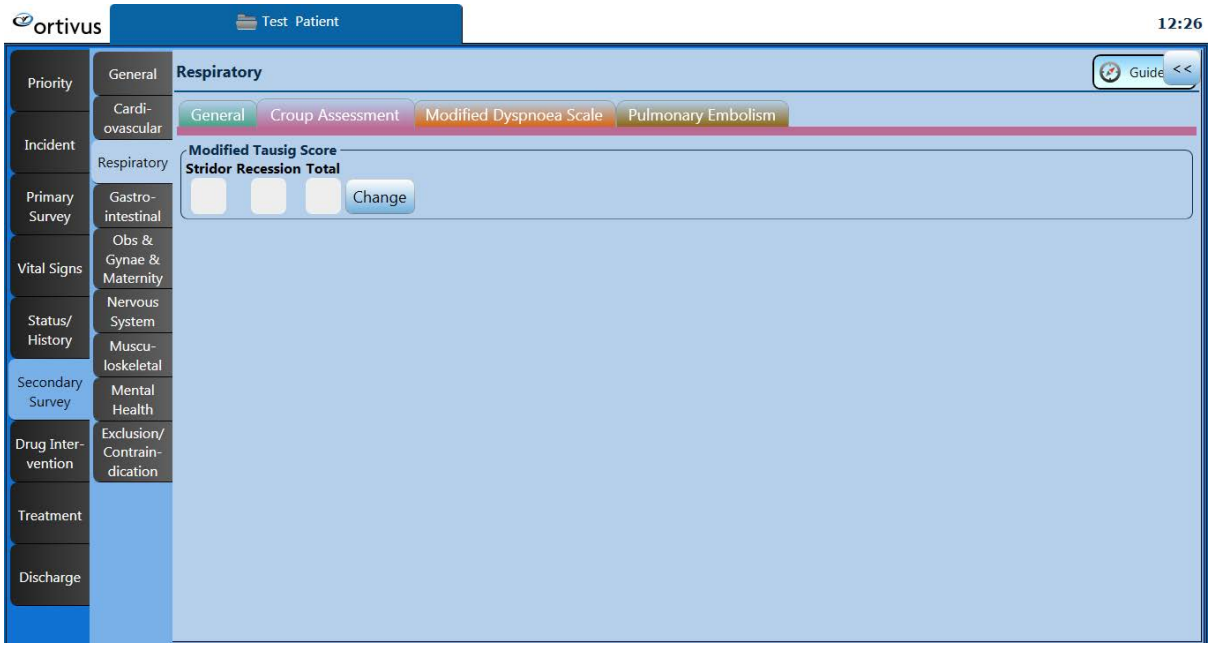
4.6.23 An additional **Free Text** field is available should further clinical information be available that is relevant to the patients respiratory function.



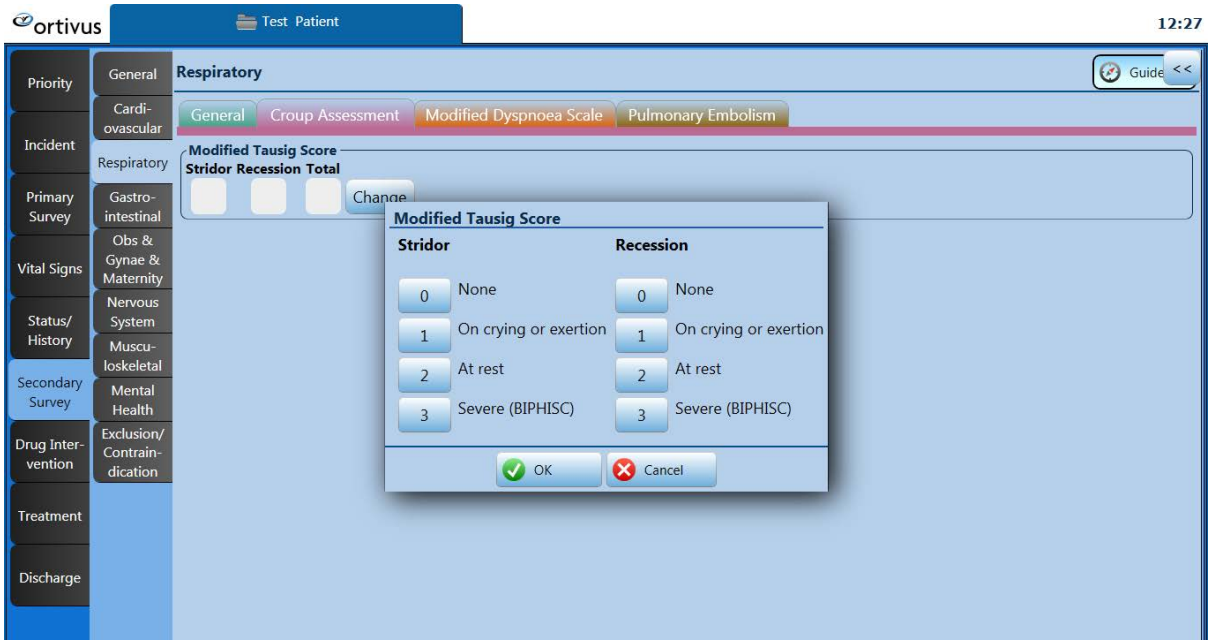
4.6.24 Once **New** within **General** assessment is selected the screen appears as below, allowing the clinician to record details of the assessment.



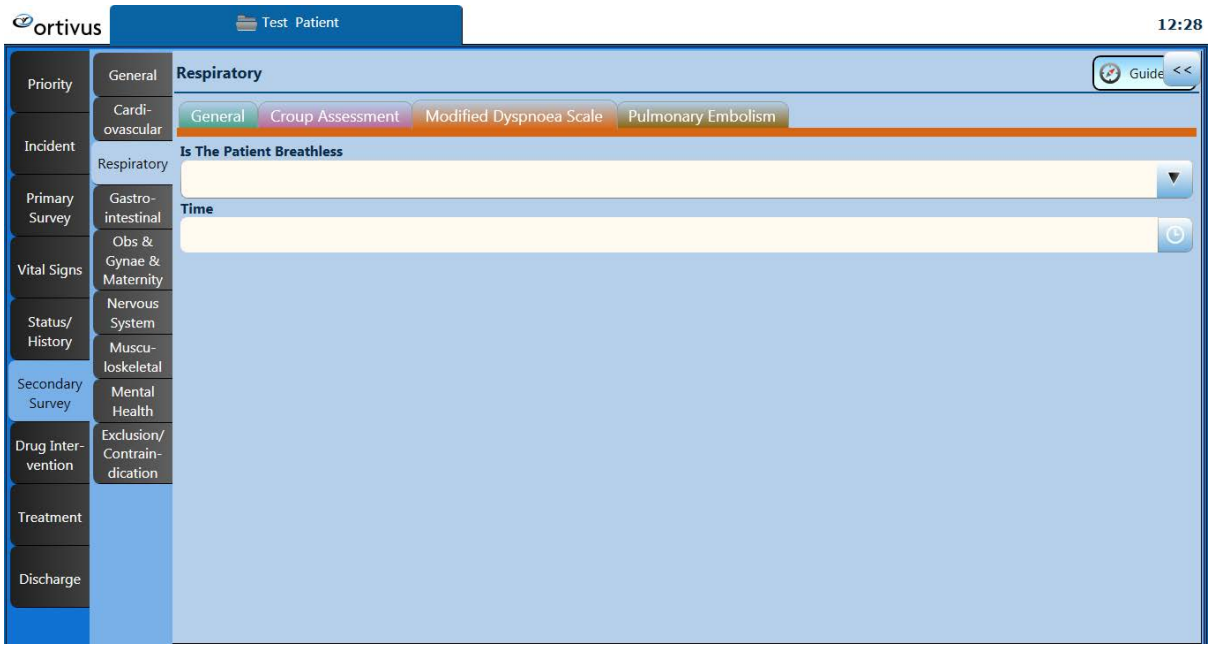
4.6.25 Should the clinician be concerned that the patient may be suffering from Croup a determination of severity is essential to the decision making process, particularly with regards onward care planning. The Modified Tausig Croup Score is an effective **Croup Assessment** tool, supported by JRCALC. In order to undertake the Croup Assessment, the clinician clicks on **Change**.



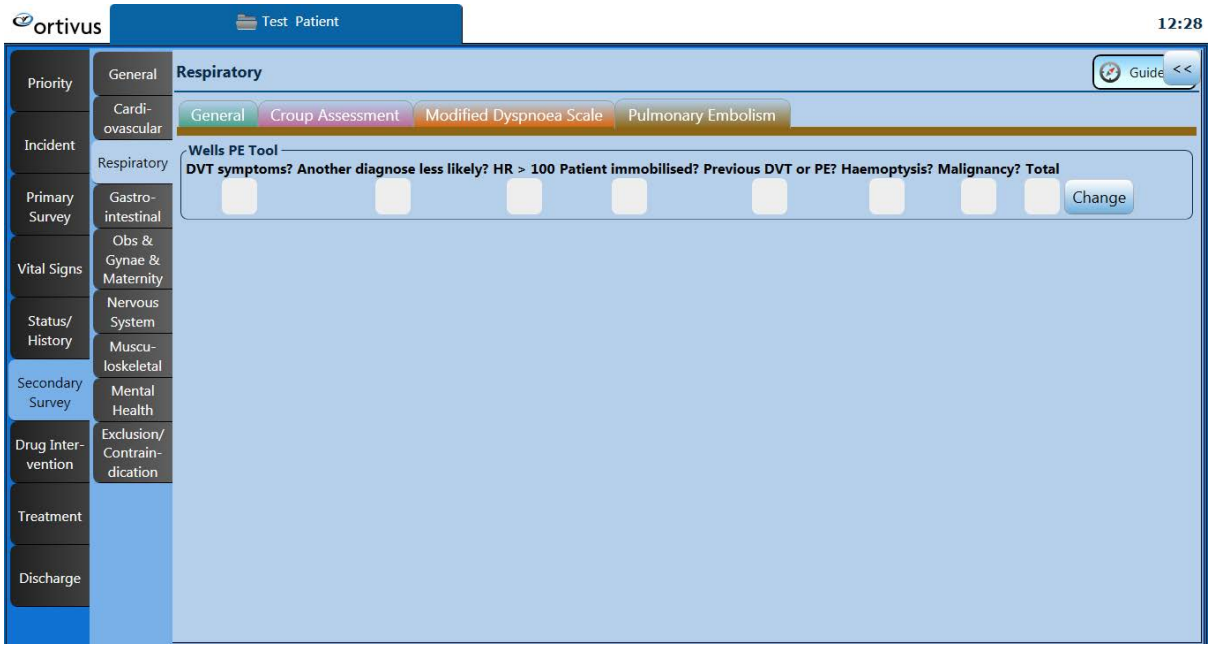
4.6.26 The **Modified Tausig Score** captures the degree of **Stridor** (a harsh vibrating sound caused by obstruction of the larynx) and the degree of **Recession**. The degree of stridor and or recession will be recorded as None, On Crying or Exertion, At Rest and Severe (Biphasic, both inspiratory and expiratory).



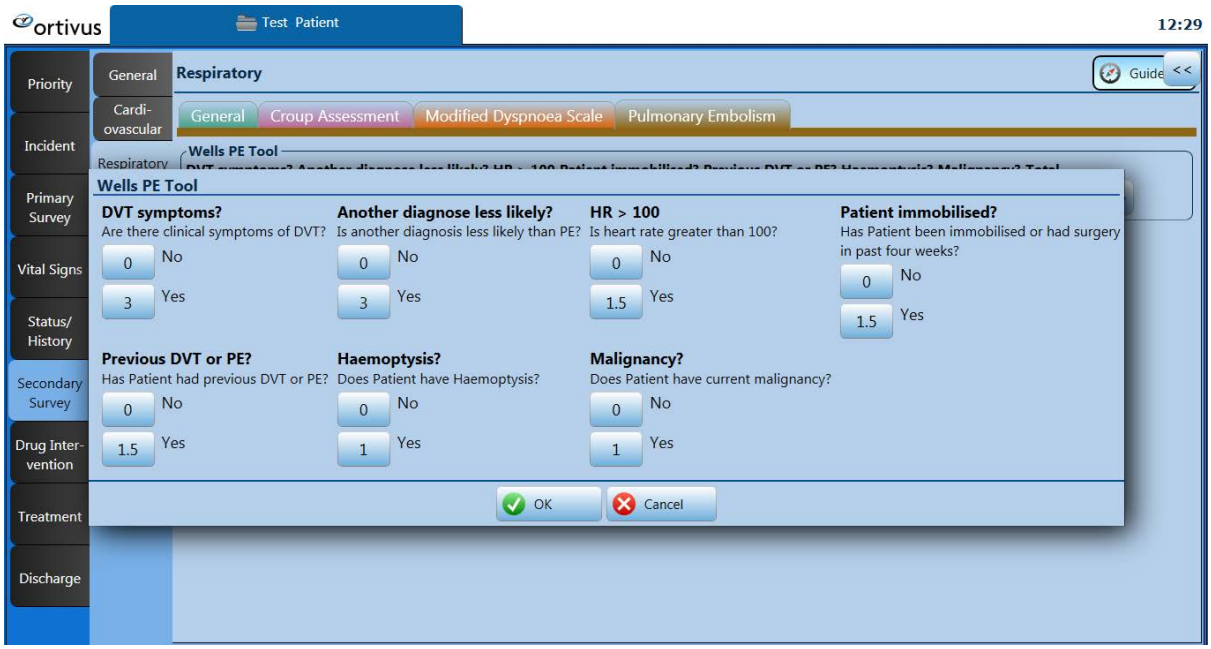
4.6.27 The **Modified Dyspnoea Scale** is used to evaluate and record the degree of breathlessness and whether this occurs at rest or at exertion. The clinician simply clicks on the down arrow to select from the list of options.



4.6.28 Similar to the Wells Deep Vein Thrombosis Tool the **Wells PE tool** assists in the risk assessment for the likely diagnosis of a **Pulmonary Embolism**. In order to undertake the assessment, the clinician selects **Change**, the PE tool checklist will then be provided for completion.

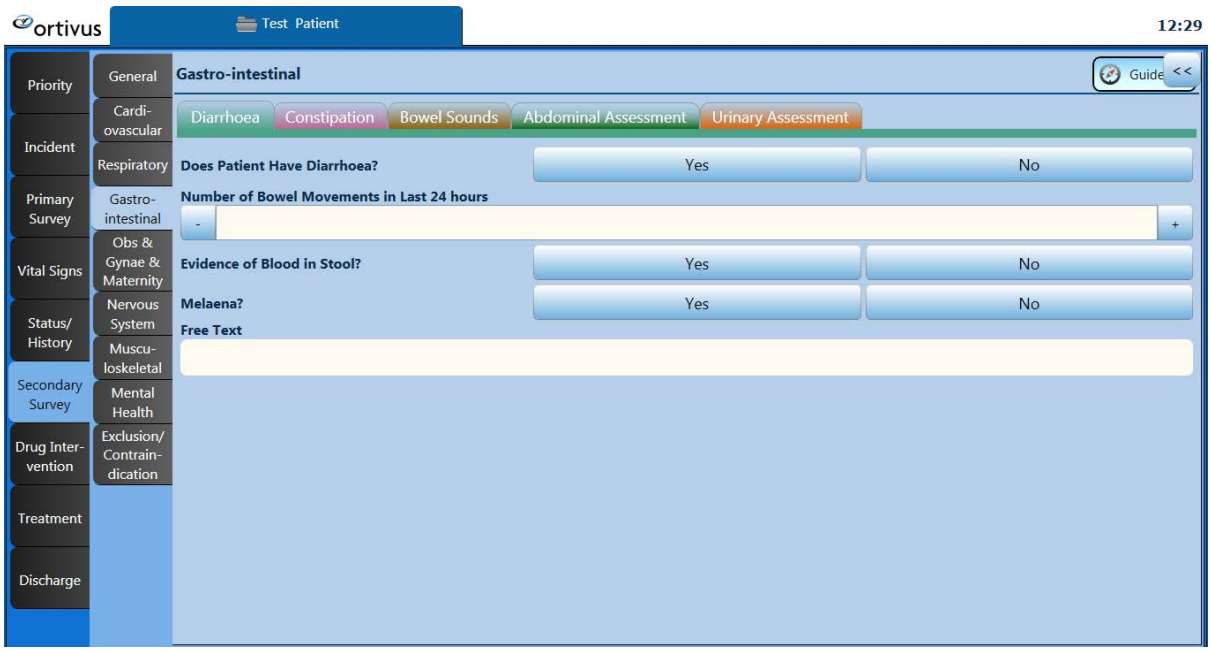


4.6.29 The Clinician will be provided with the checklist as below, the clinician simply answers the questions presented and clicks Ok, the risk of **PE** is then provided to support the clinicians ongoing care plans.

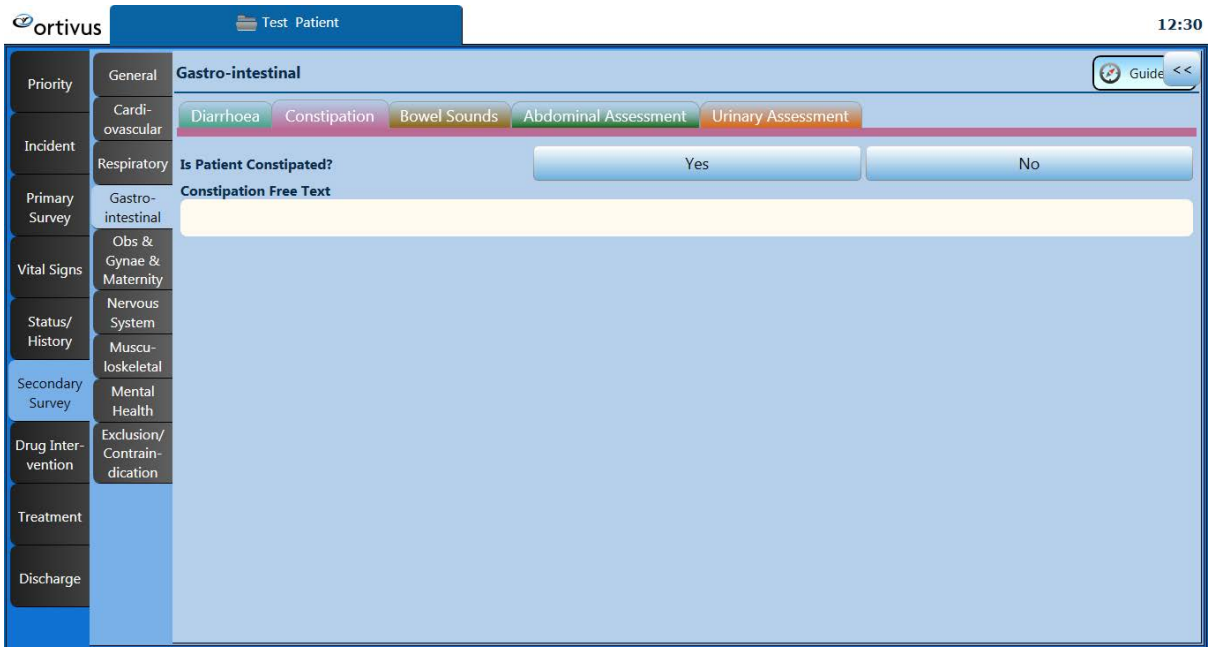


4.6.30 The Gastro-intestinal screen has a number of tertiary tabs that support an depth assessment of the patient.

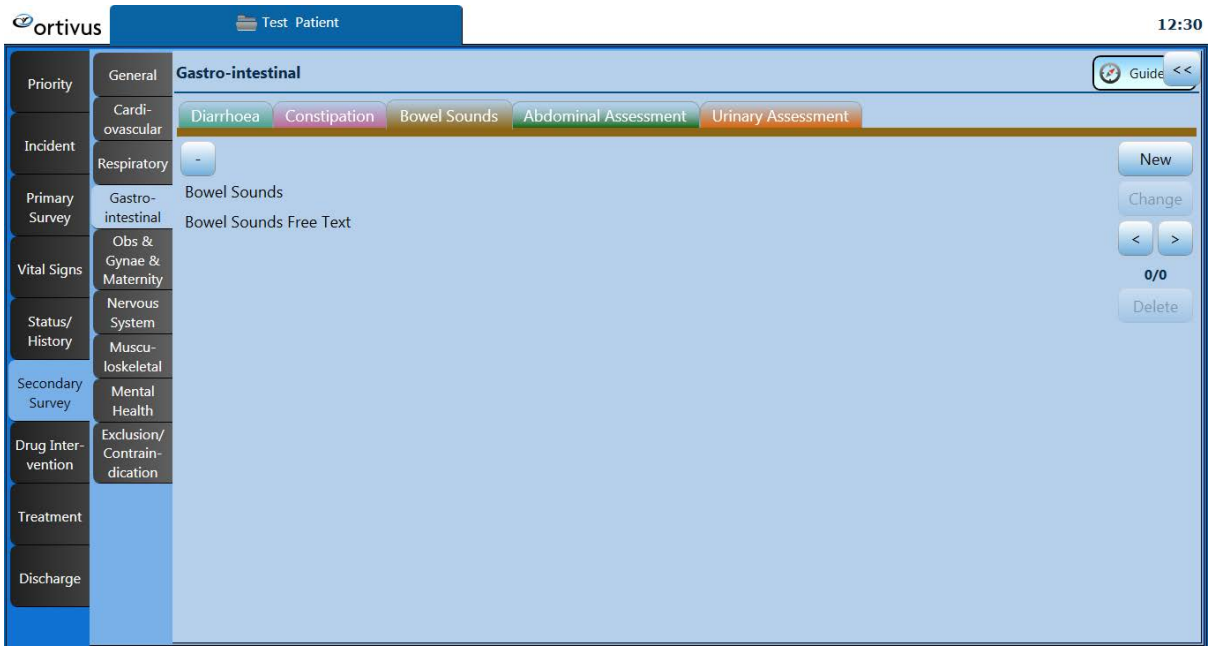
4.6.31 The screen opens on the **Diarrhoea** screen, this enables the capture of data relating to diarrhoea in both tick box format and also with an additional free text field for the capture of information not entered elsewhere.



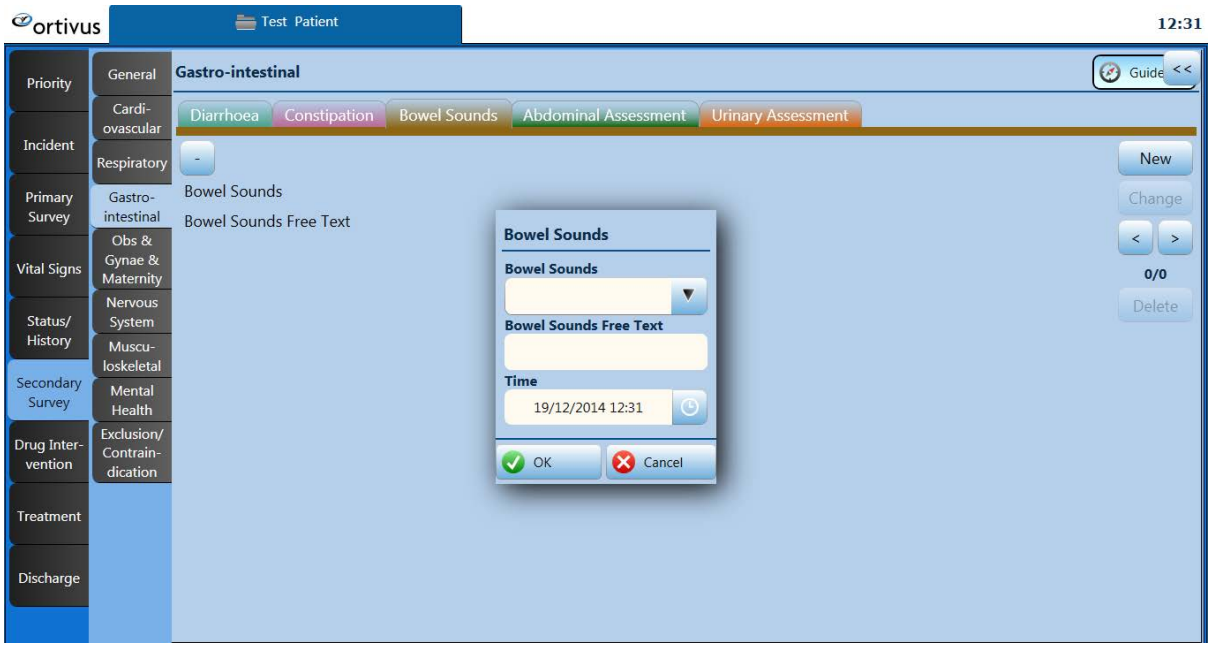
4.6.32 **Constipated** screen enables the clinician to capture information relating to any patient who appears to be constipated. Data fields are available as either a simple **Yes**/**No** or in a free text format.



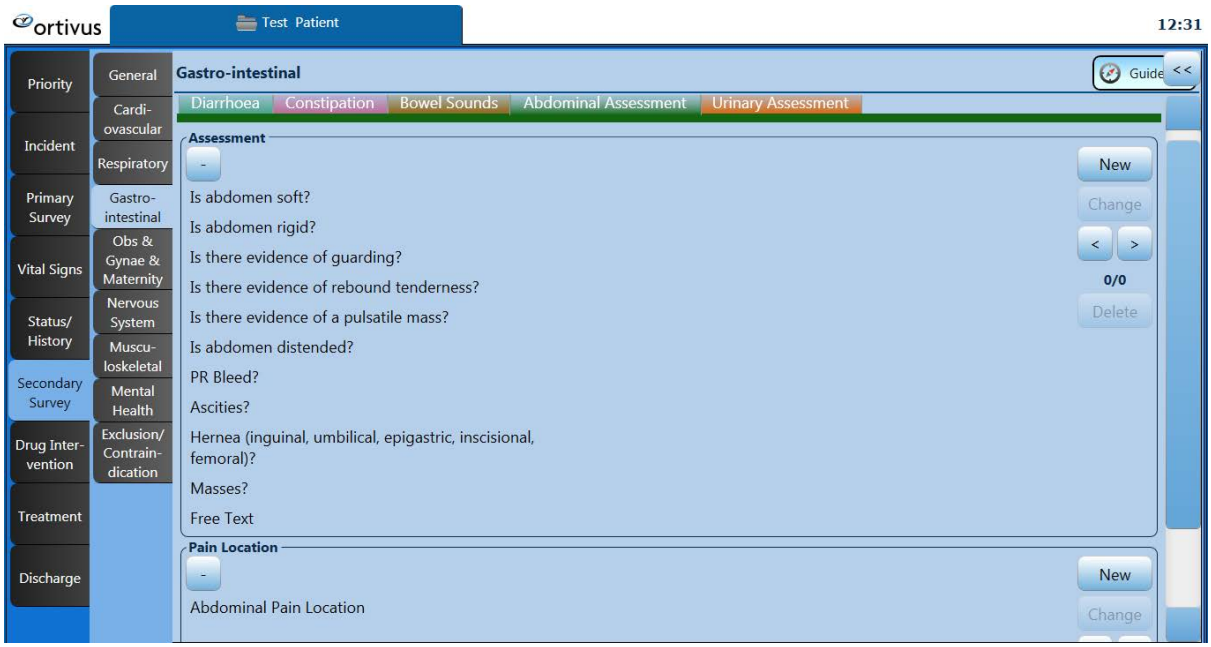
4.6.33 For those able to appreciate the nature of bowel bounds and conduct an appropriate assessment. The **Bowel Sounds** screen enables the clinician to enter details by clicking the New button.



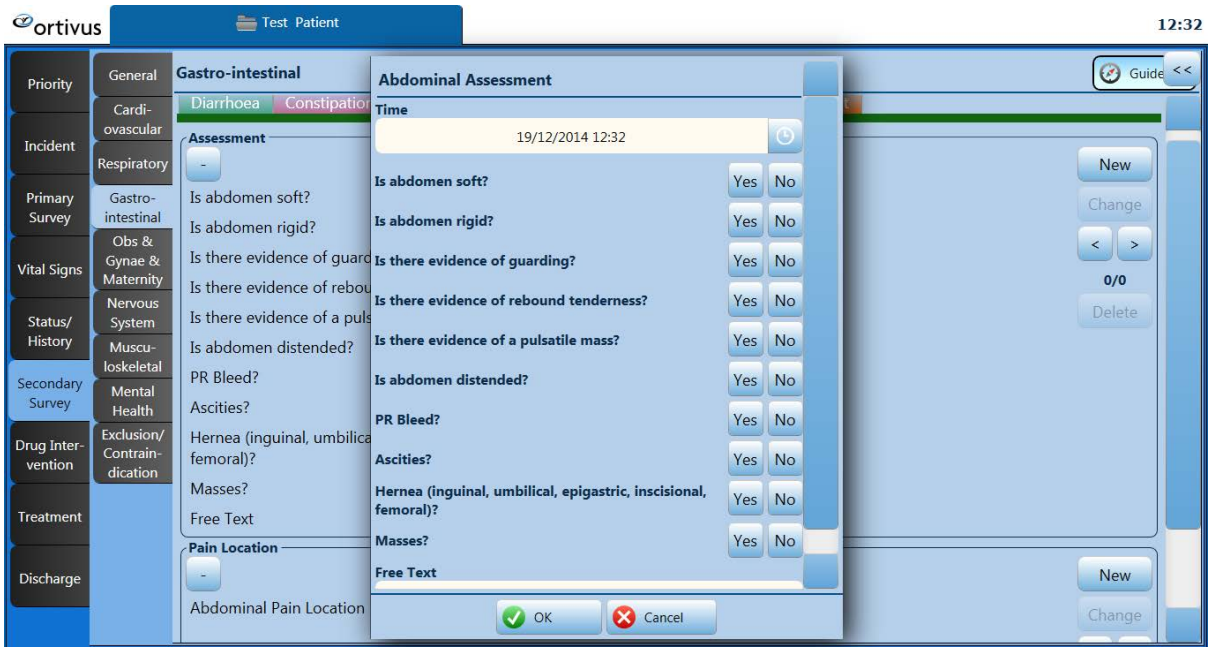
4.6.34 Once clicked the following data box appears, the clinician can then click on the down arrow to bring up a drop down list of **Bowel Sounds** and also has the option of entering additional free text.



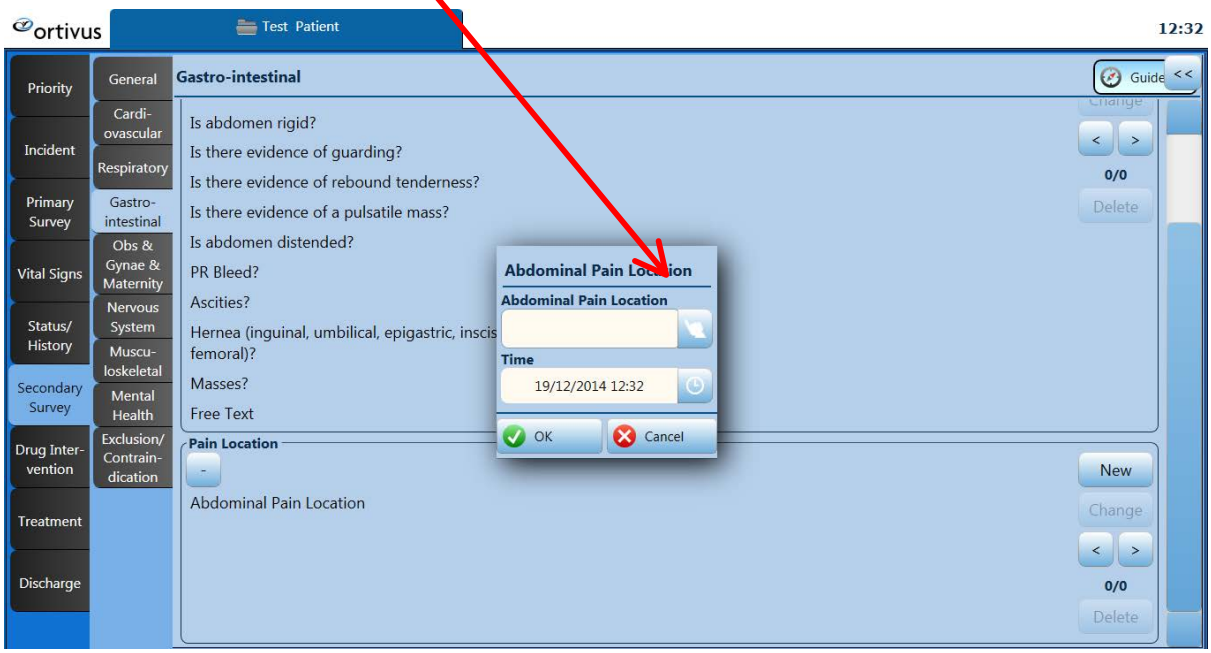
4.6.35 A generalised **Abdominal Assessment** can be located and recorded by clicking the New button.



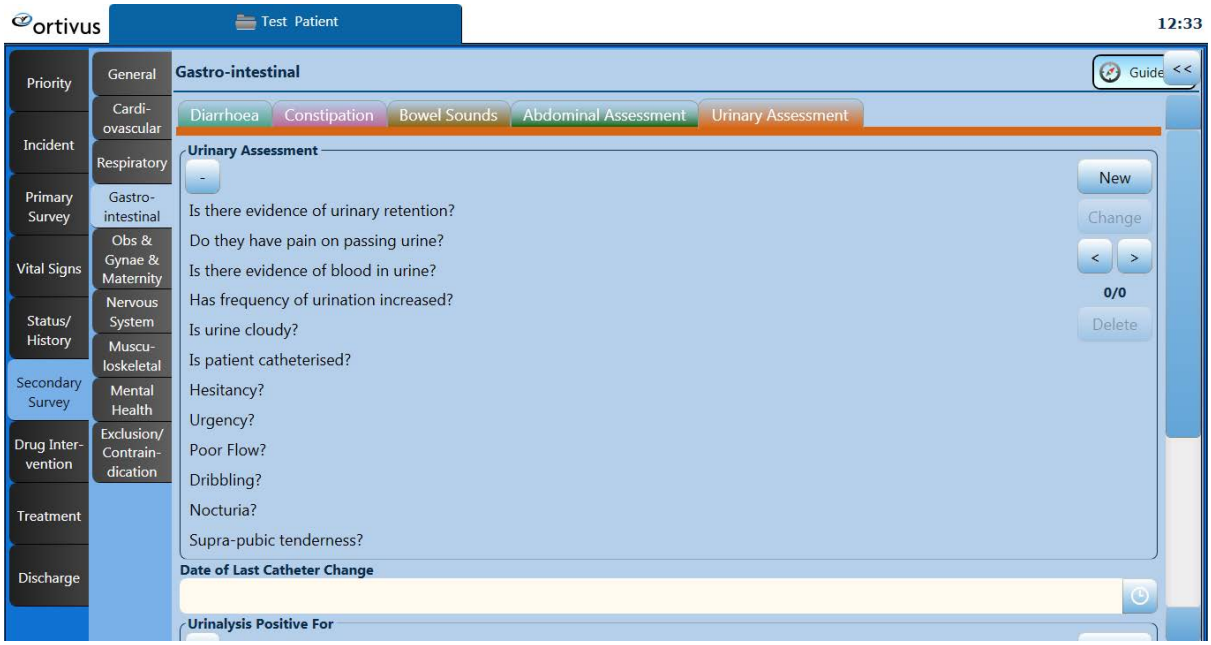
4.6.36 Once the **New** button is clicked the clinician can enter details of a generalised abdominal assessment by clicking on the **Yes**/**No** buttons. Any additional information can be entered in the **Free Text** field.



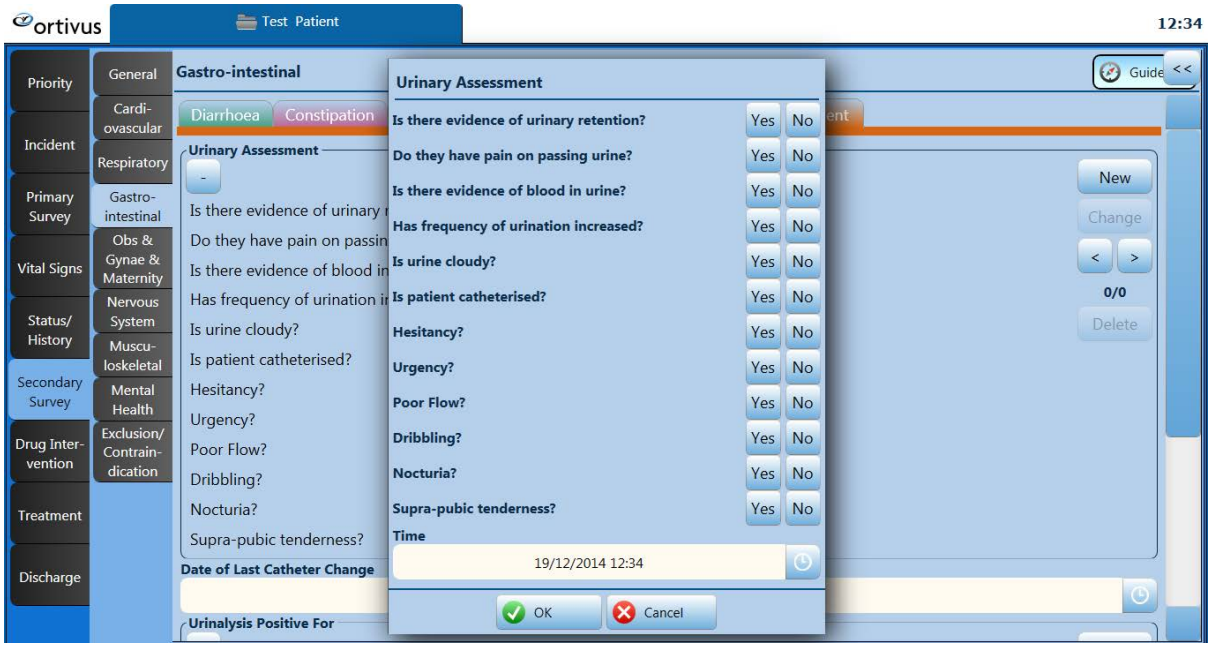
4.6.37 In order to identify the location of any abdominal pain the clinician first clicks on the **white finger symbol**, this then opens up a checklist of abdominal regions that can be used to select or multi select areas of pain.



4.6.38 A generalised **Urinary Assessment** can be accessed by clicking the **New** button. Additionally, if the patient is catheterised, it is important to enter the **Date of Last Catheter Change**, this may be important when considering any retention and any requirement to organise a catheter change via ECP or district nurse etc.

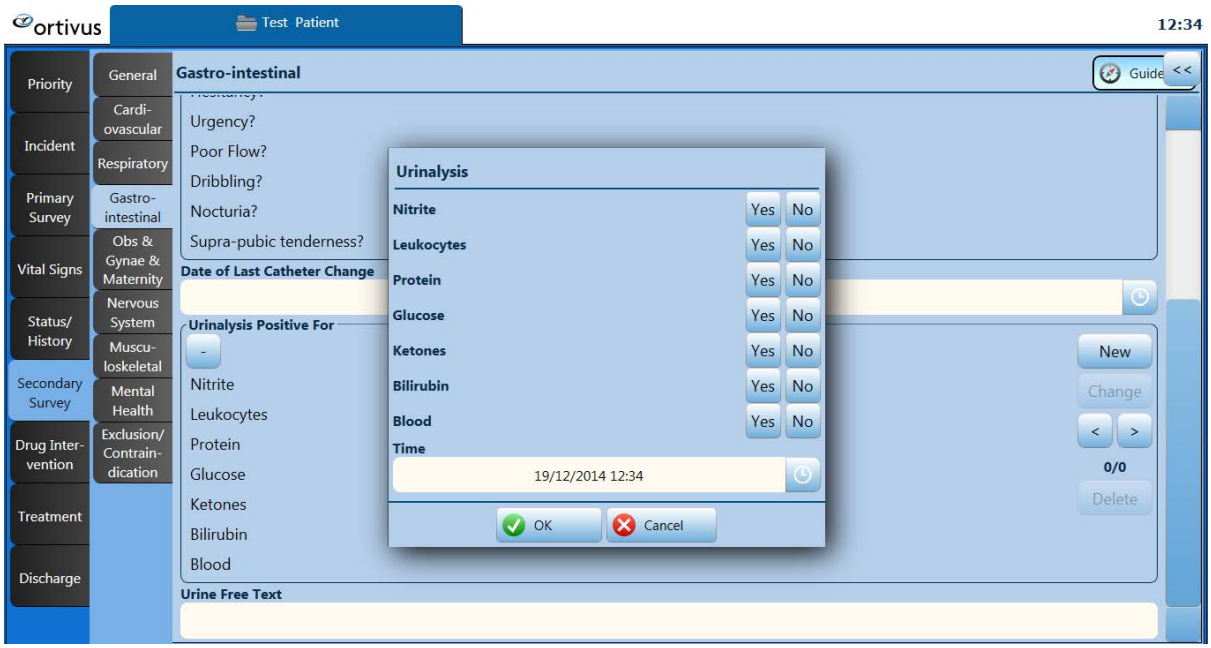


4.6.39 Details of the Urinary Assessment by clicking on the **Yes**/**No** buttons.



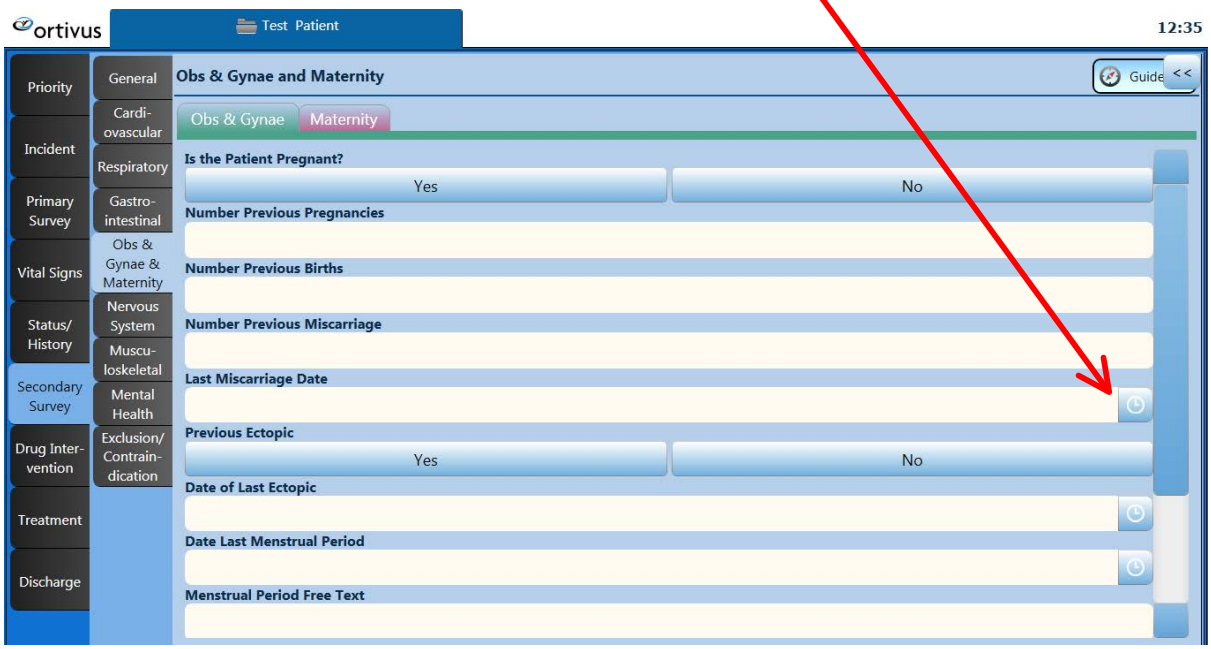
4.6.40 For Emergency Care Practitioners and those able to perform **Urinalysis**, this functionality is included with the configuration. As other assessments, Urinalysis results can be entered by clicking the **New** button. Any additional information not covered within the generalised **Urinary Assessment** or **Urinalysis** can be entered in the **Urine Free Text** field.

4.6.41 Details of the Urinalysis assessment can be entered into the ePCR by clicking on the **Yes**/**No** buttons, followed by Ok.

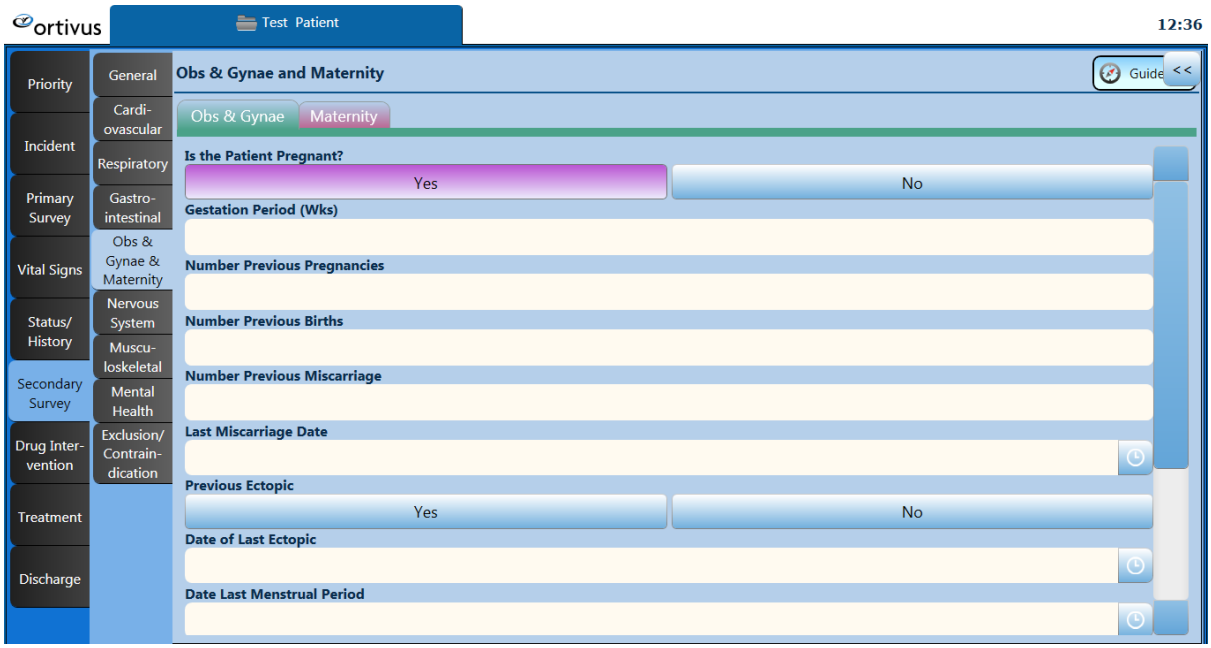


4.6.42 Information relevant to the patients Obstetric and/or Gynaecological status can be entered within the **Obs & Gynae** screen. Data can be entered either as simple Yes/No or as free text or numerical data fields. Where a "**Number**" is required, this should be entered using numerical inputs (1,2,3, etc.).

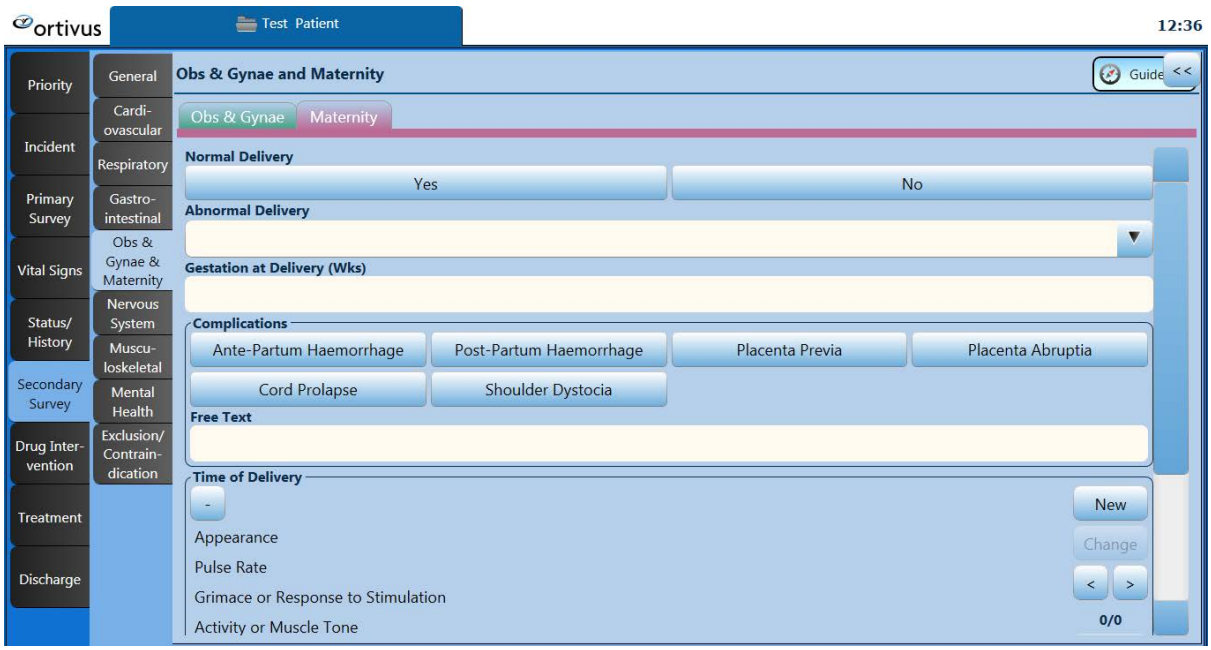
4.6.43 As with other Date/Time fields, the **Date of Last Ectopic** or any other **Date** field can be adjusted by clicking on the **clock symbol** and then using the **+** and **−** buttons as appropriate.



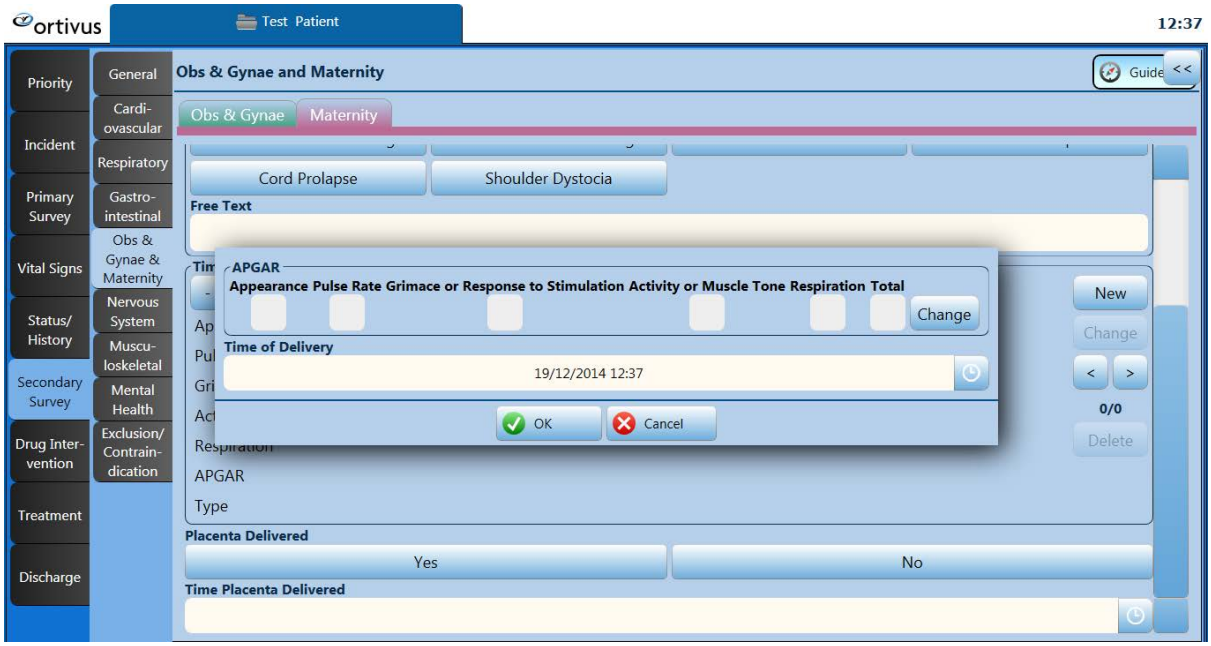
5.6.44 In order to reduce the visibility of buttons unless they are required, the **Gestation Period (Wks)** field will only appear if the question **Is the Patient Pregnant** is answered **Yes**.



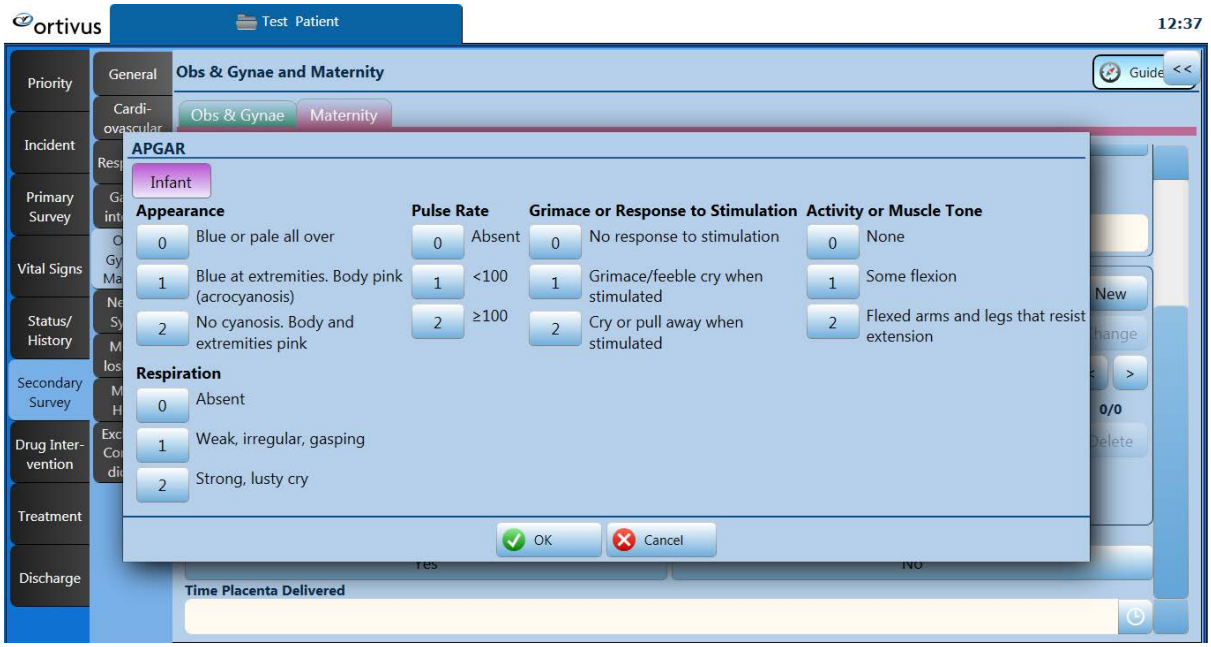
4.6.45 The **Maternity** Screen enables the clinician to enter details of any child birth, this will include simple **Yes**/**No** buttons, drop down menus such as **Abnormal Delivery** to capture details including breech birth dystocia etc and also **Free Text** fields to capture any information relating to the delivery that are not captured elsewhere. This may include the nature of the birth, water birth for example or any other information felt relevant such as the time of labour.



4.6.46 In order to capture the **Time of Delivery** and also the **APGAR** score of the newborn, a multiple time field is provided to support the occasions of both single and multiple births. The clinician simply clicks on the **New** button to open the APGAR screen, the time Of Delivery as with other time fields will be pre-populated, but can be adjusted by clicking the **clock symbol**.

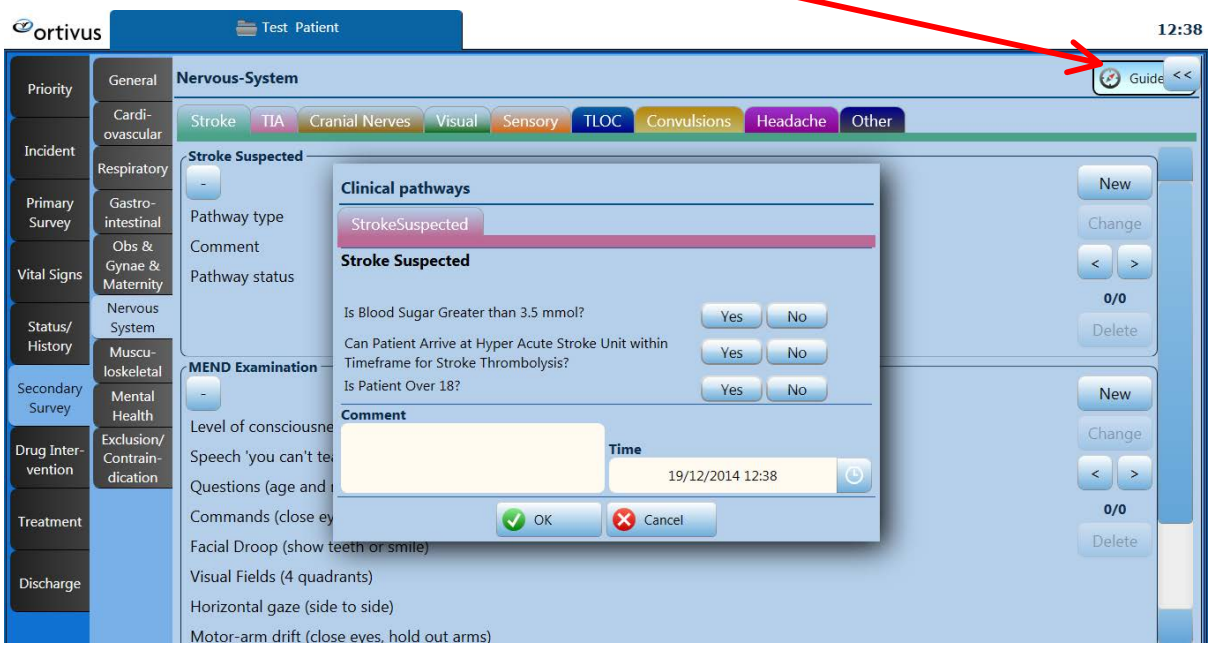


4.6.47 In order to enter details of the **APGAR** score, the clinician clicks the **New** button and the following screen will appear. The clinician answers all the questions by clicking on the appropriate buttons, the total APGAR score will be provided once the **Ok** button is clicked.

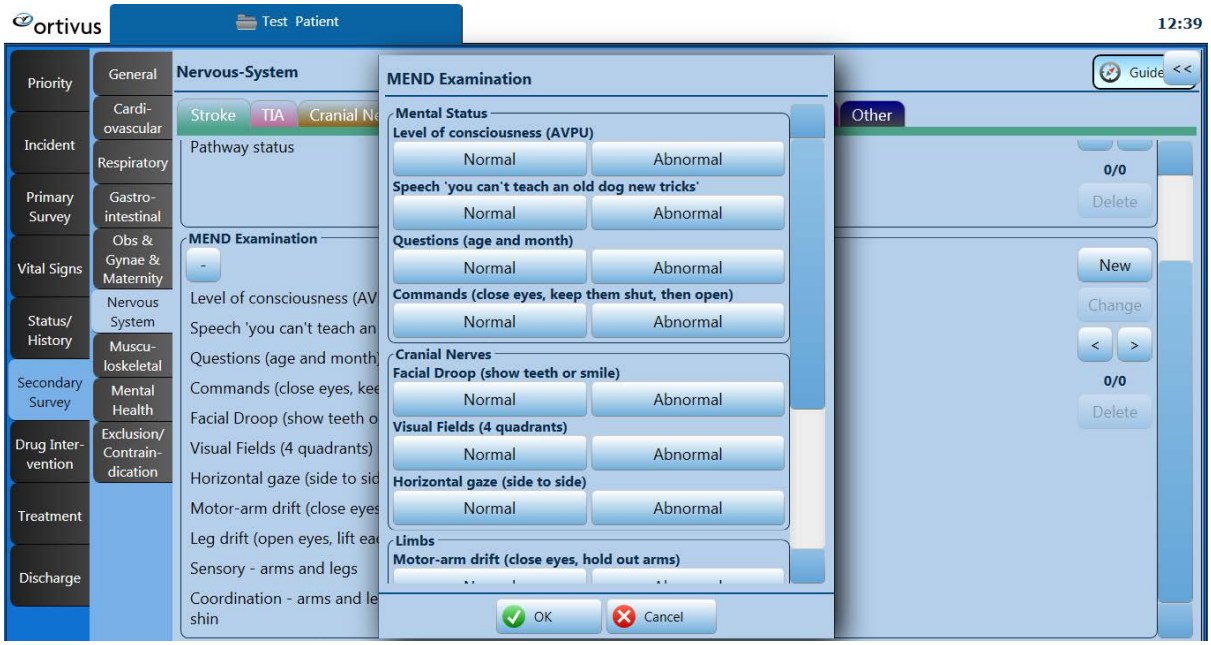


4.6.48 The **Nervous System** screen has a number of tertiary tabs across the top of the screen that enable the clinician to enter details of the assessment of the patient neurological function. These include, **Stroke**, **TIA** (Transient Ischeamic Attack), **Cranial Nerves**, **Visual** assessment, **Sensory** assessment, **TLOC** (Transient Loss of Consciousness), **Convulsions**, **Headache and Other** to capture any further neurological assessment not captured elsewhere.

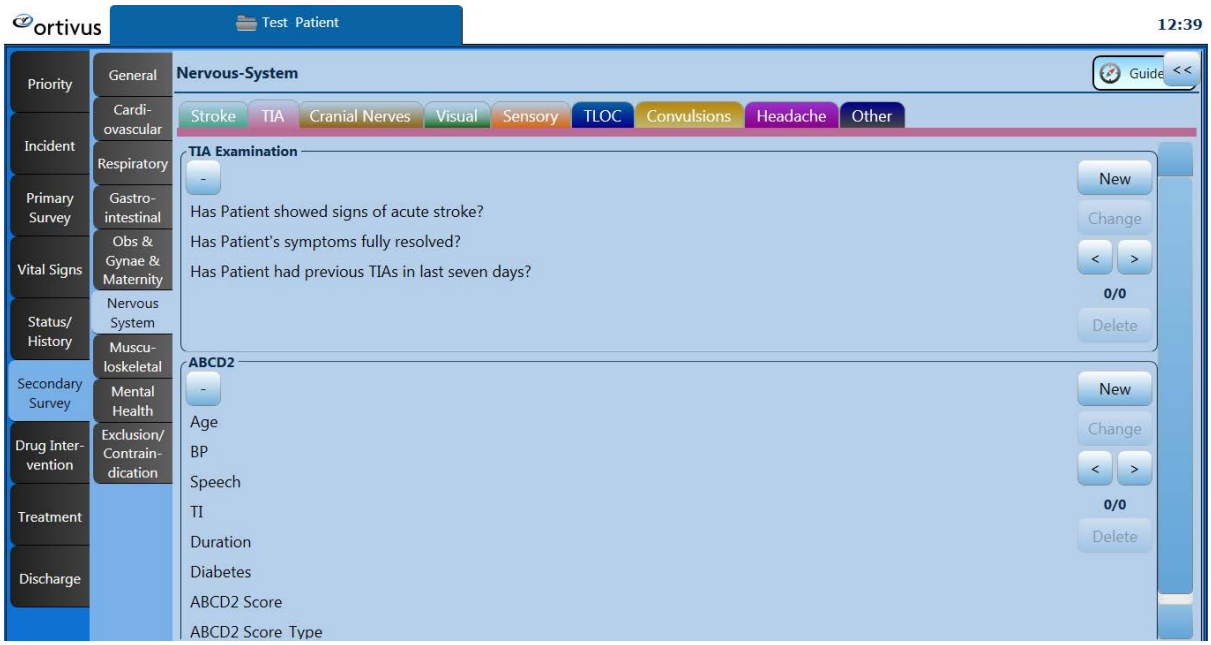
4.6.49 The **Stroke** screen allows the clinician to evaluate whether the patient is suitable for conveyance to a hyper acute stroke centre, in line with Clinical Guidelines. On clicking the **New** button, the screen as below is displayed. The three qualifying questions are asked and if all **Yes**, the patient is deemed suitable for conveyance to the hyper acute stroke centre. Timeframes for conveyance are contained within the relevant Clinical Guideline, this can be accessed via the **Guidelines** button on the screen or via the Guidelines function on the **Main Menu** screen.



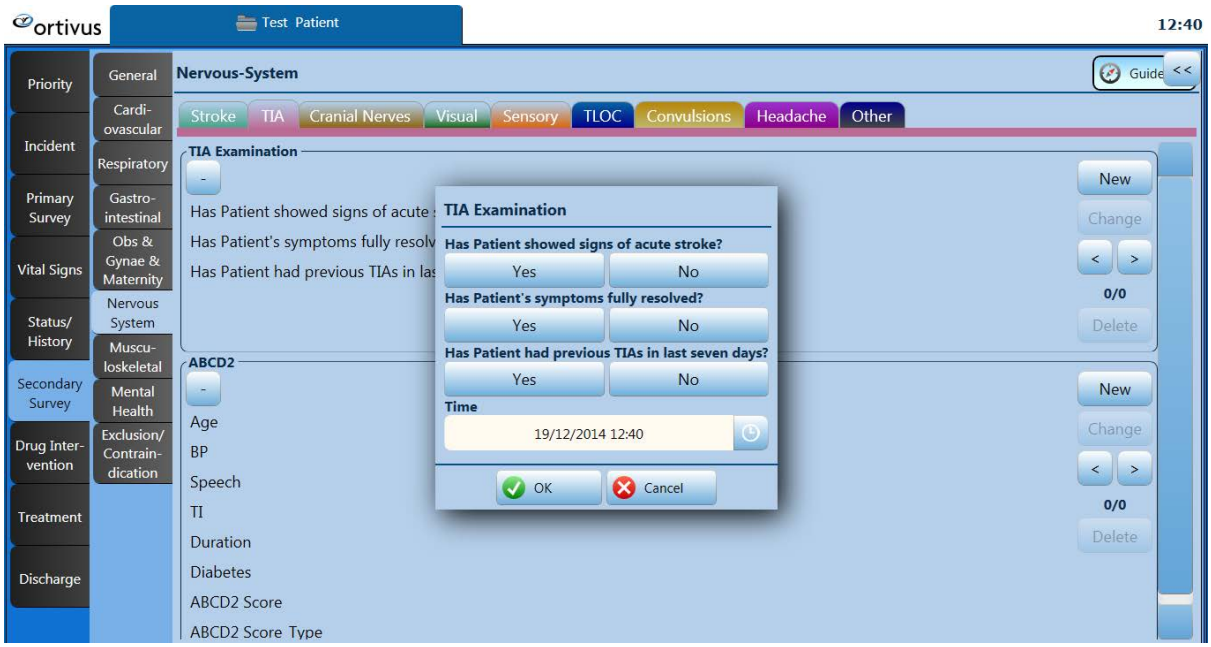
4.6.50 The **MEND** exam supports the clinician in the evaluation of patients suspected of having suffered a Stroke. The clinician evaluates several parameters and records them as **Normal** or **Abnormal** by clicking on the appropriate button. Once completed the clinician clicks **OK**.



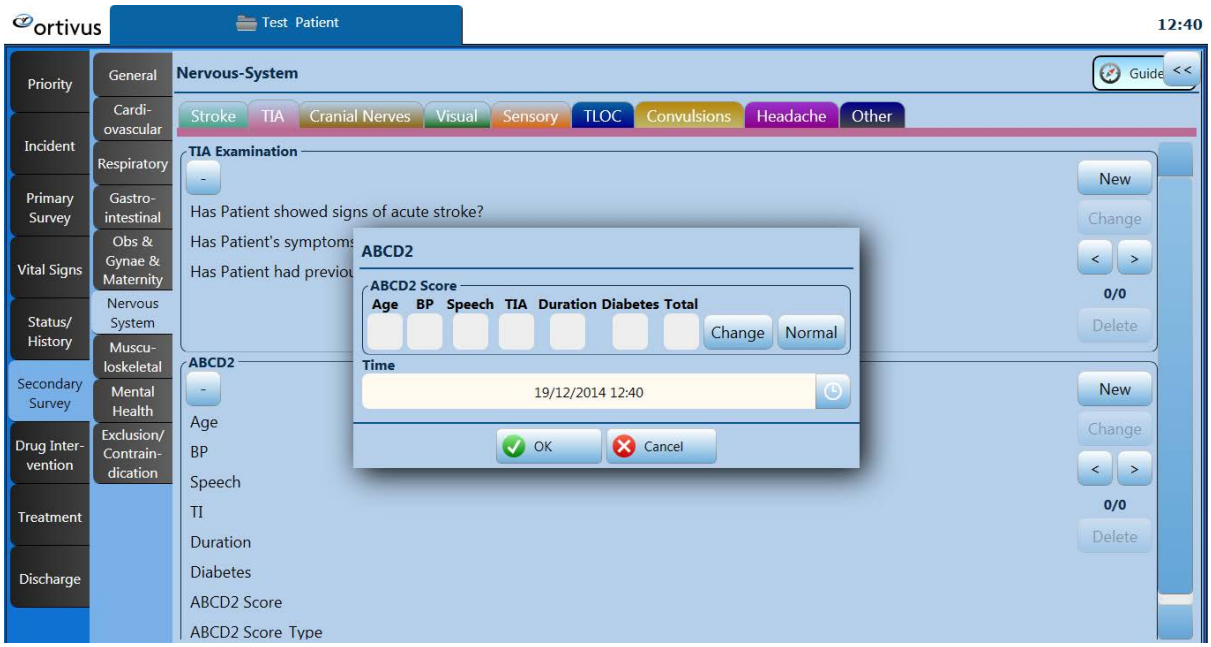
4.6.51 Should the clinician consider that the patient may have suffered a TIA, the **TIA** screen allows for data entry to support a structured **TIA Examination** and also to capture the **ABCD2** score, by clicking on the appropriate **New** button.



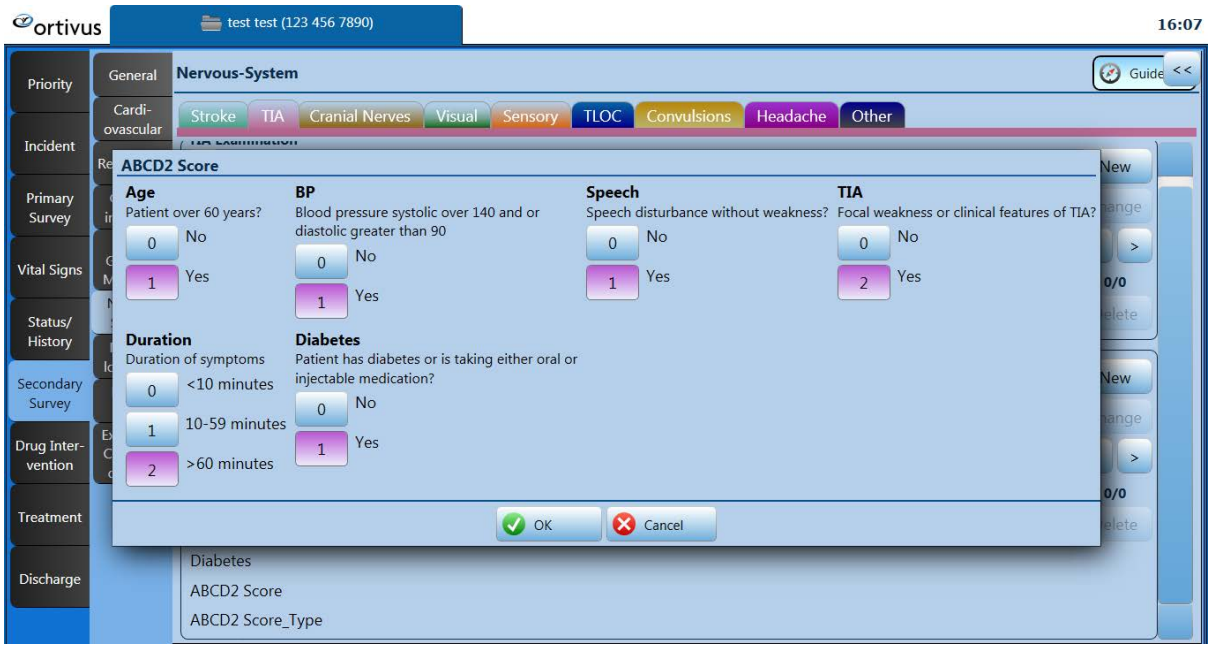
4.6.52 The **TIA Examination** screen opens up a short series of questions to support the evaluation of TIA. The clinician selects **Yes** or **No** as appropriate and the clicks **Ok**.

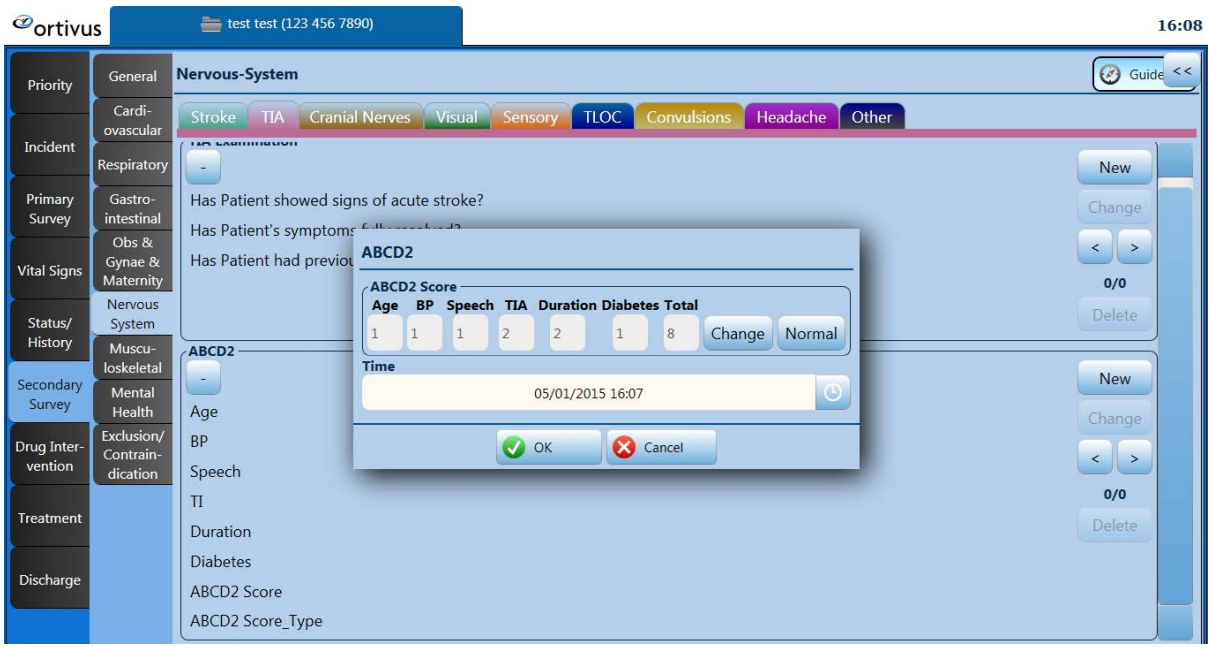


4.6.53 The **ABCD2** score estimates risk of stroke after a TIA. In order to calculate this score the clinician clicks on **Change** to enter the calculation tool.

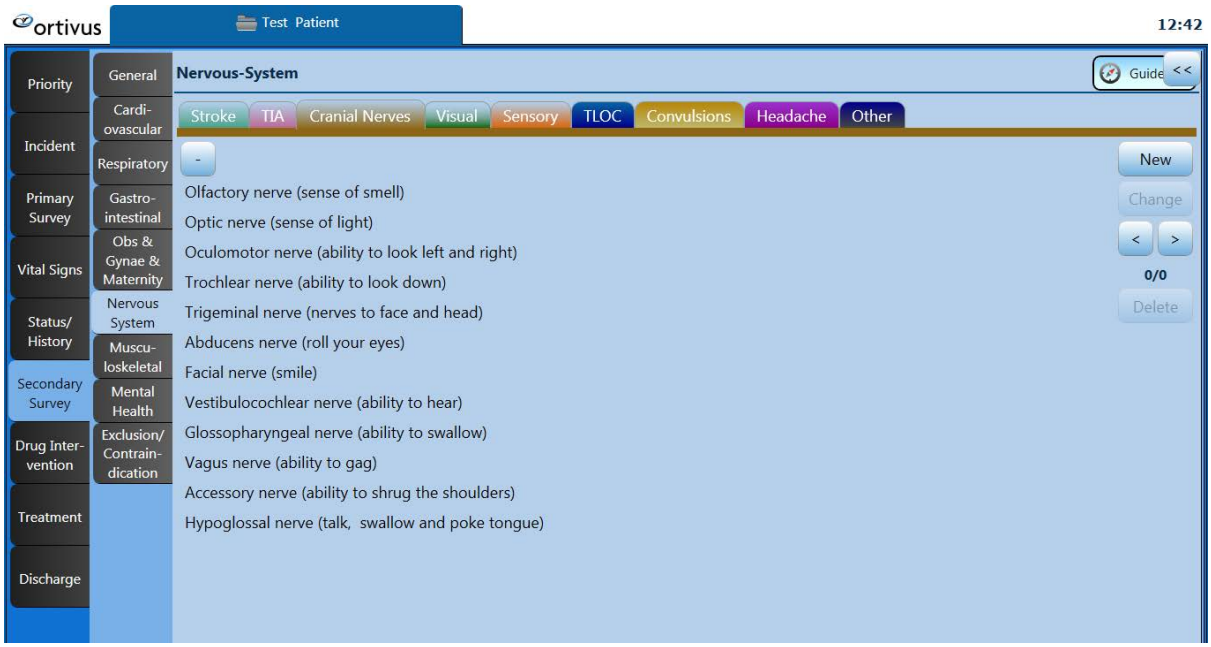


4.6.54 The Clinician uses the **ABCD2** tool to answer the questions as presented, once all questions are answered the clinician clicks **Ok** and the screen will return to the **TIA** screen and display the total **ABCD2 Score** as below.

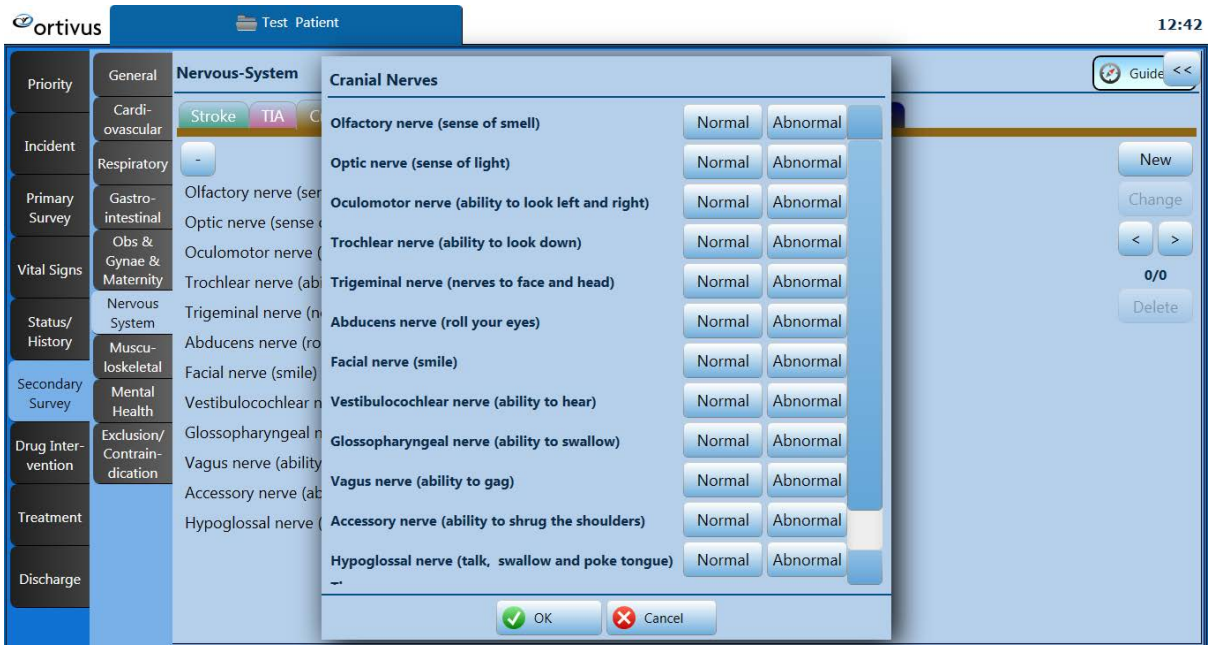




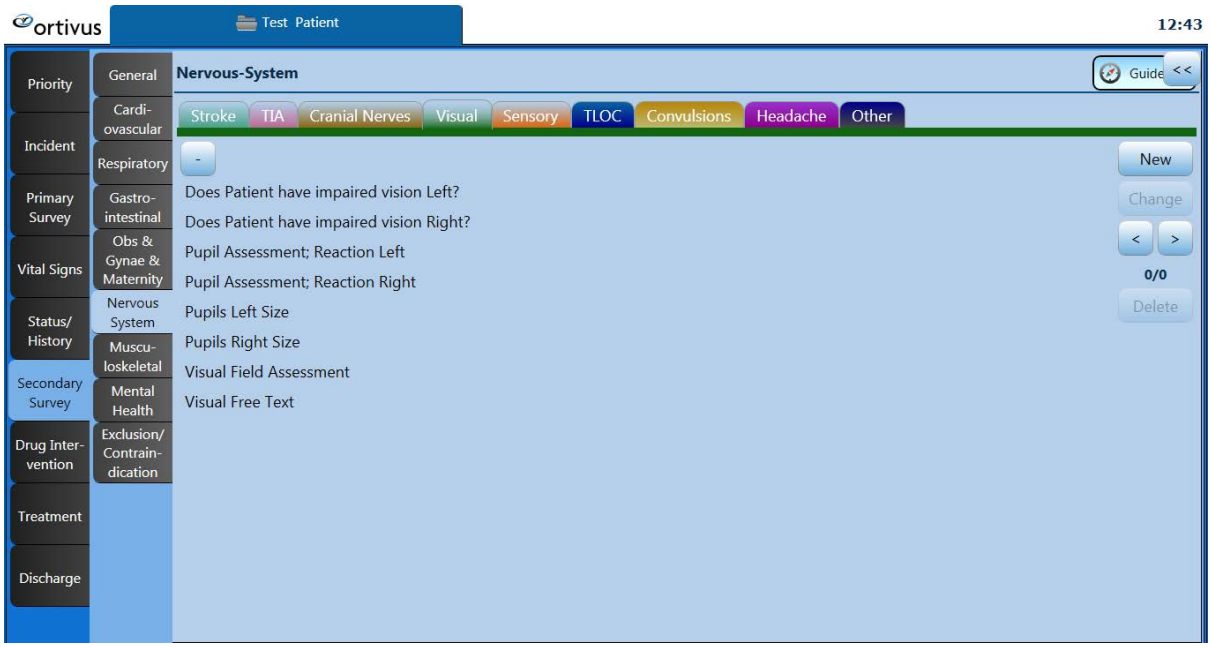
4.6.55 Should the clinician wish to document an assessment of the **Cranial Nerves**, the **New** assessment button is clicked, this then opens up the assessment box.



4.6.56 The clinician reviews each Cranial Nerve in turn and enters either a finding of **Normal** or **Abnormal** as indicated. Once all **Cranial Nerves** have been assessed and recorded the clinician clicks **Ok**.

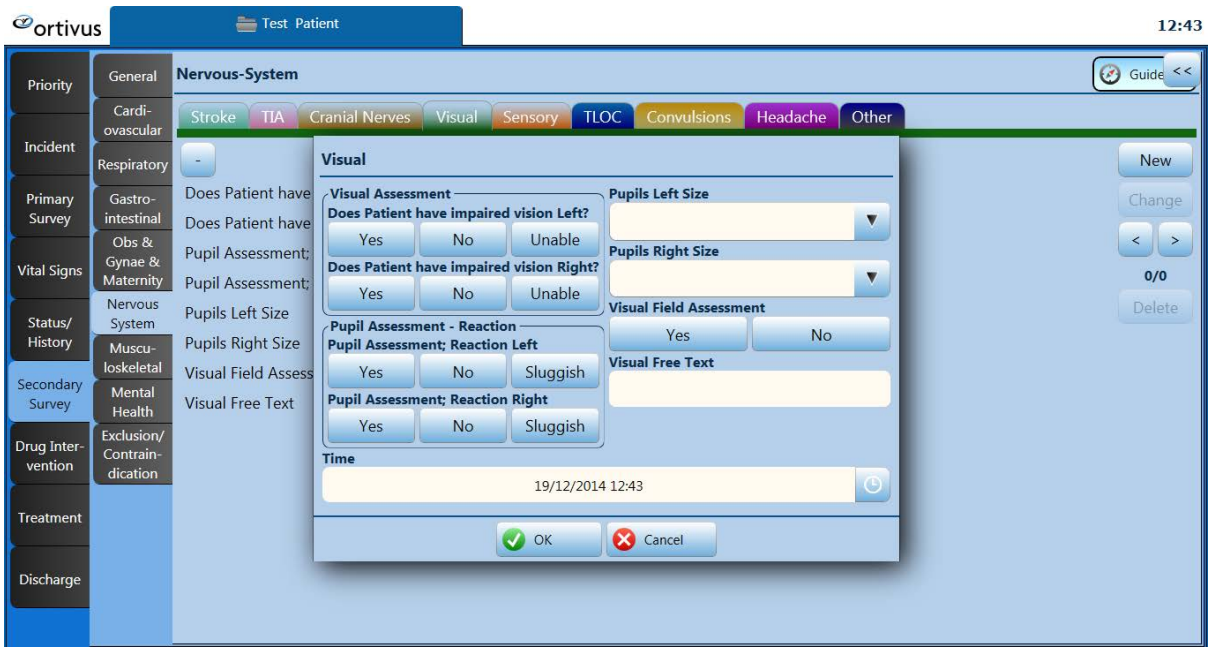


4.6.57 The clinician can enter details of an assessment of the patients **Visual** status by clicking the **New** button.

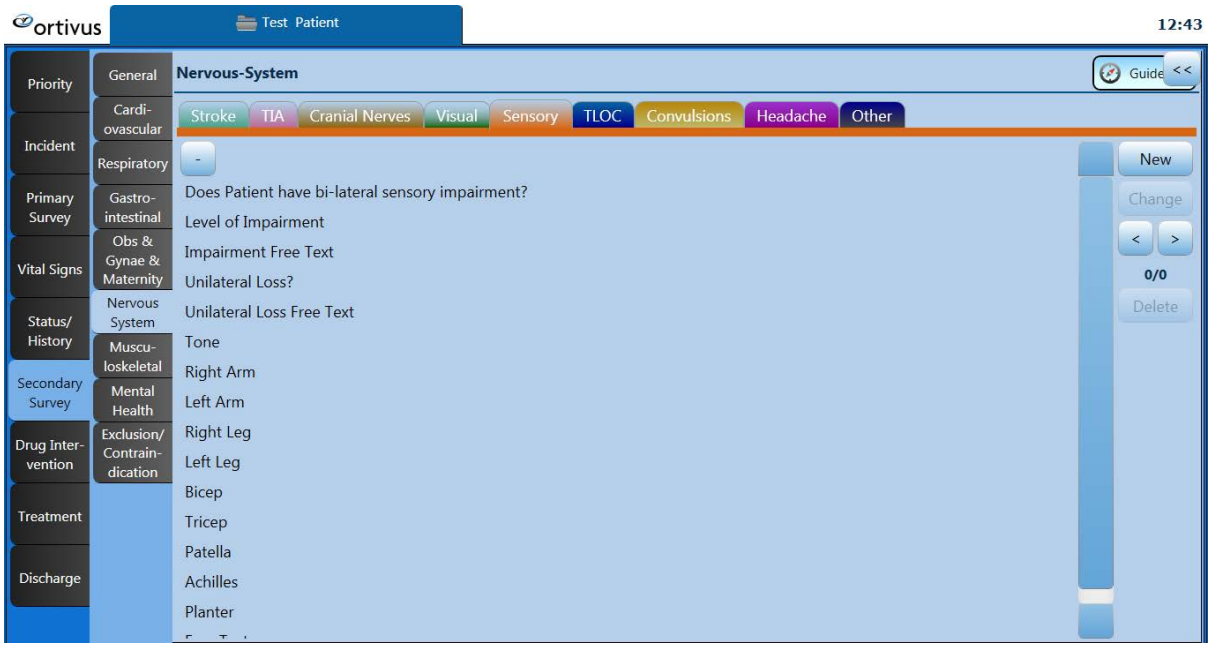


4.6.58 Details of the **Visual** assessment can be entered using the appropriate buttons as below. The size of the pupil can be entered by clicking on the down arrow and selecting the appropriate size in mm.

4.6.59 Any additional details such as impairment of visual fields or presence of hyphema (blood in the eye) etc can be captured using the **Visual Free Text** field provided.

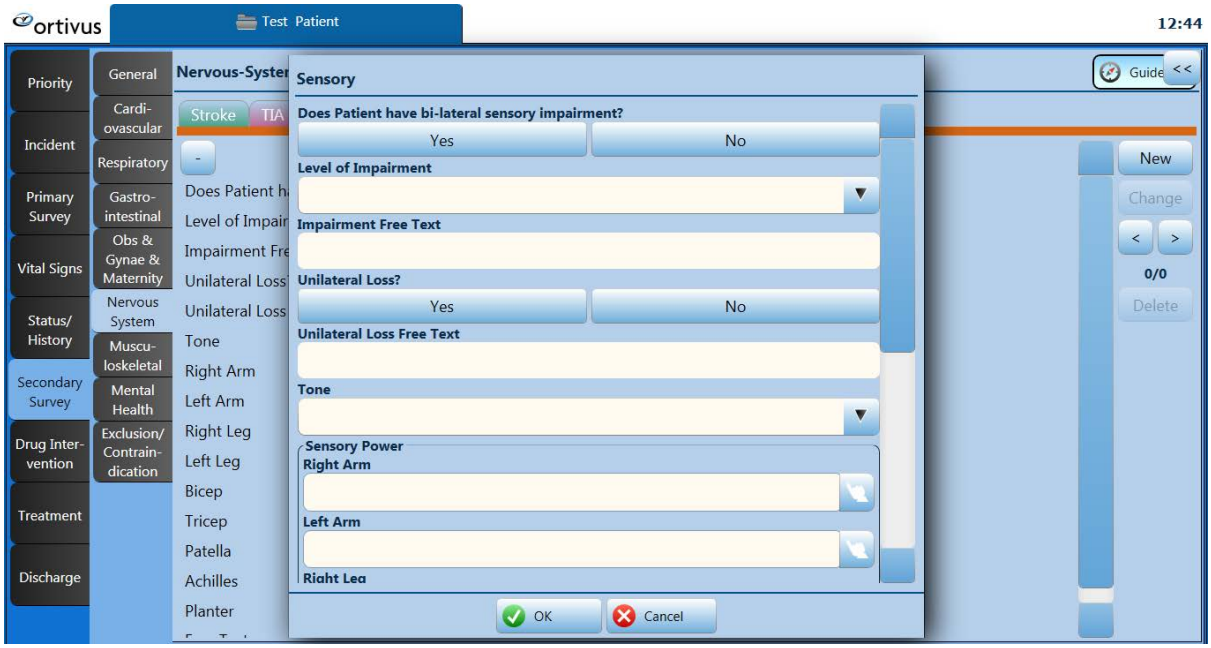


4.6.60 The clinician can enter details of an assessment of the patients **Sensory** status by clicking the **New** button.

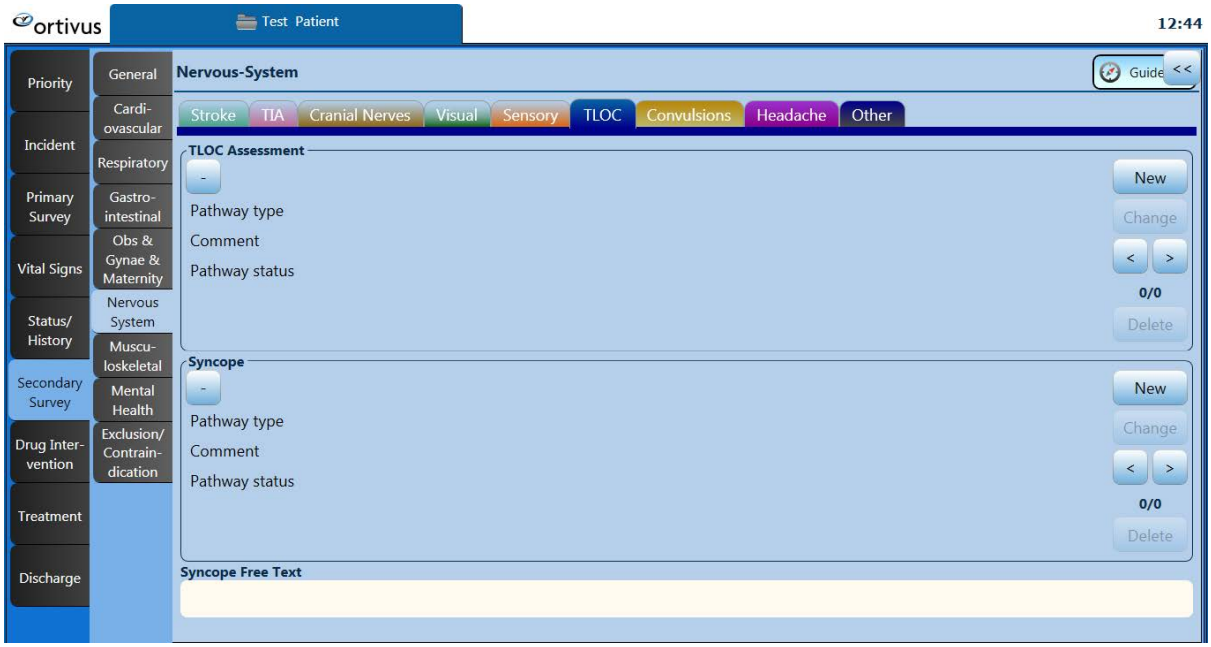


4.6.61 The **Sensory** assessment enables the clinician to review loss of sensation **Tone** and **Sensory Power**. This may be supportive of an assessment of spinal injury or spinal compression and assist in determining the location of any injury.

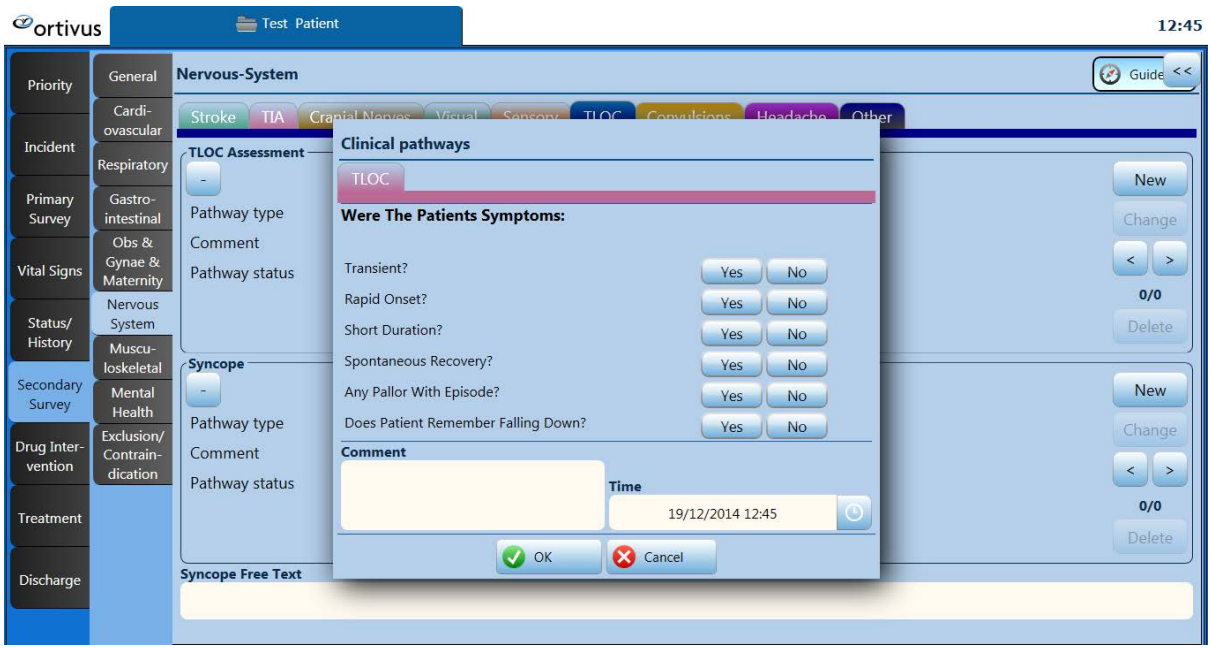
4.6.62 Any bi-lateral loss could be indicative of spinal insult, the **Level of Impairment** field below, allows the clinician to approximate the level of impairment by relating the loss to the relevant dermatome.



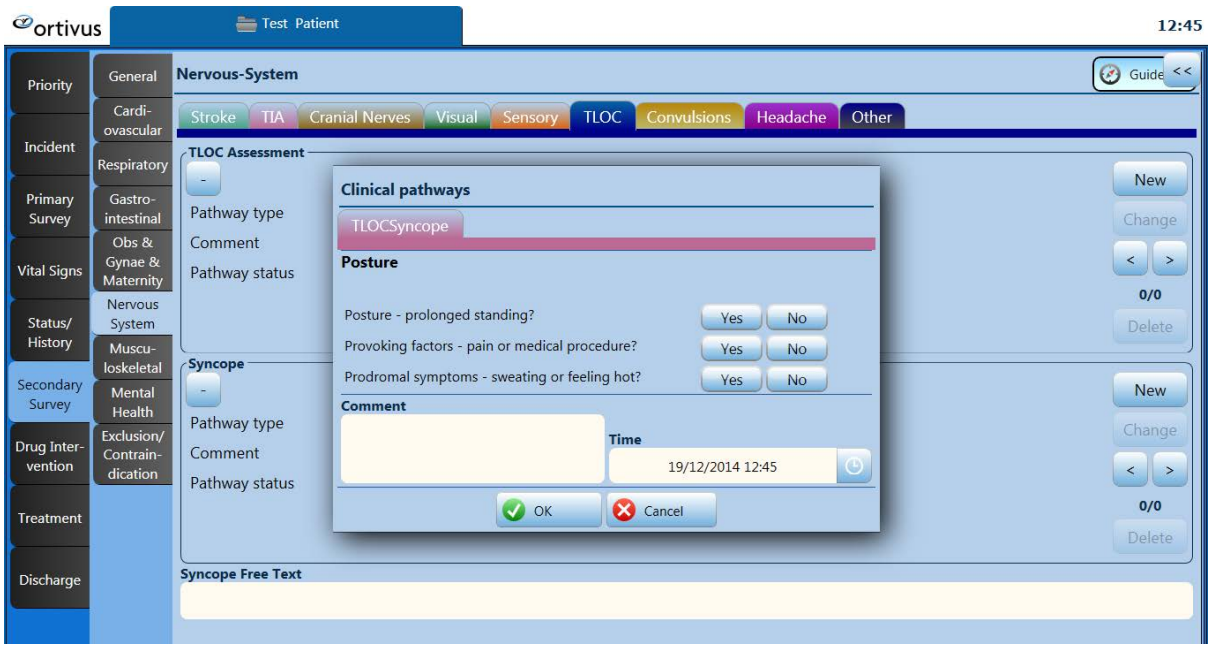
4.6.63 Should the clinician be called to a patient with suspected **TLoC** (Transient Loss of Consciousness), the **TLoC** screen assists in providing a structured assessment, following guidance from NICE. The **TLoC** and **Syncope** assessments can be accessed by clicking the relevant **New** button.



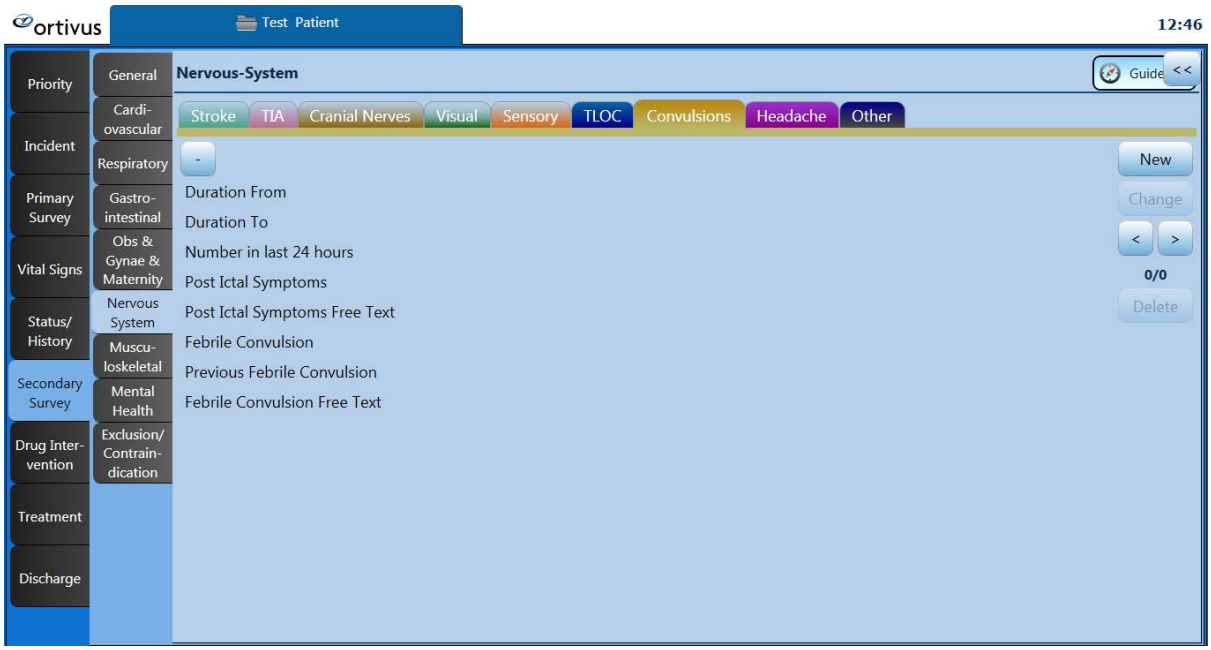
4.6.64 The clinician will be provided with a number of questions which support them in determining whether any collapse is suggestive of **TLoC** or has a more sinister aetiology. Should all questions be answered **Yes**, the risk of serious aetiology without other indications is considered low. Any additional information not captured elsewhere can be recorded within the **Comment** free text field.



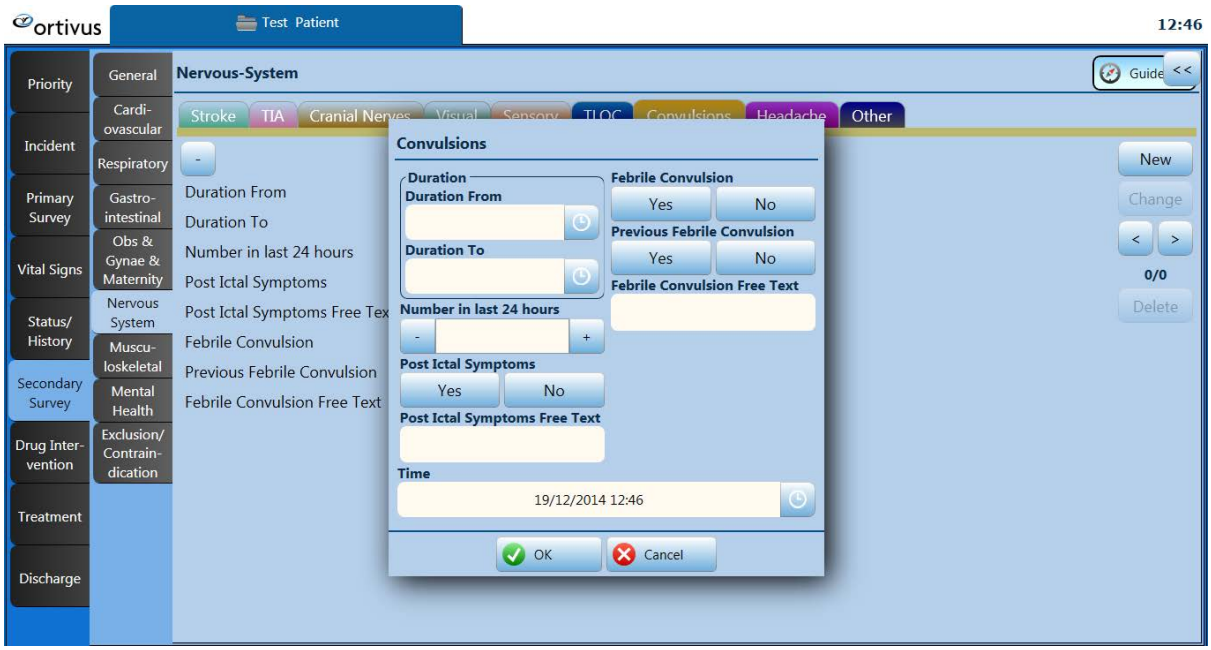
4.6.65 On selecting the Syncope assessment the clinician will be provided with a number of questions which support them in determining whether any collapse is suggestive of **Syncope** or has a more sinister aetiology. Should all questions be answered **Yes**, the risk of serious aetiology without other indications is considered low. Any additional information not captured elsewhere can be recorded within the **Comment** free text field.



4.6.66 The **Convulsions** screen enables the clinician to document findings in relation to any convulsion or seizure activity. To access the assessment the clinician clicks on the **New** button.

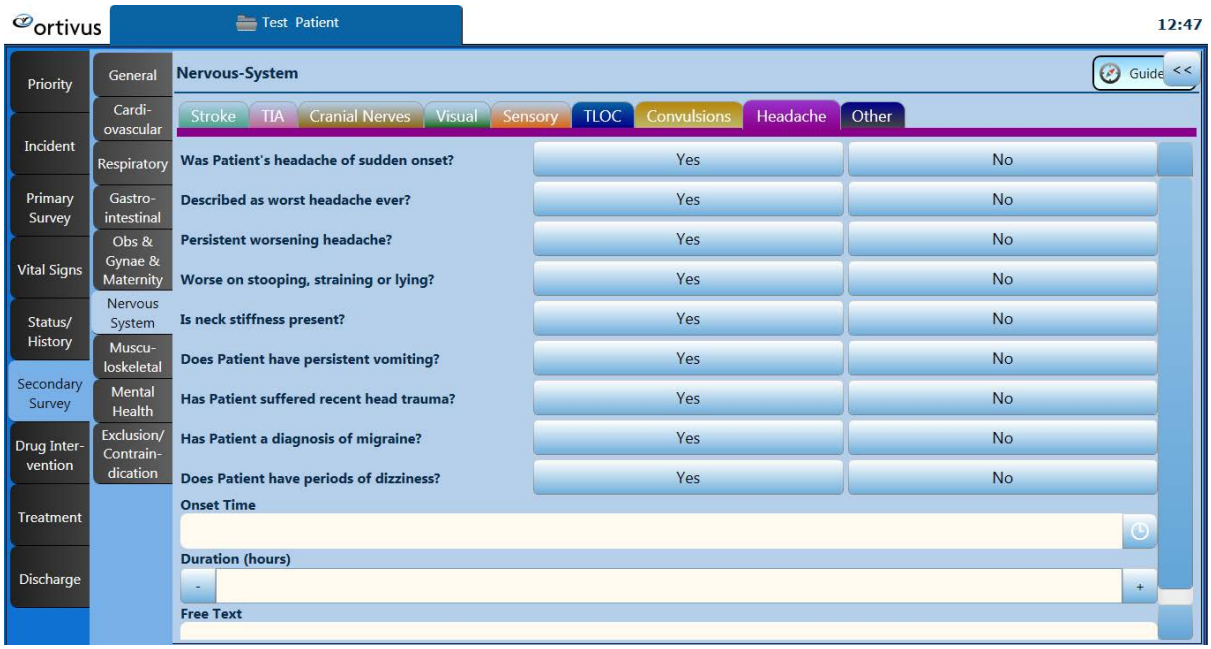


4.6.67 The **Convulsions** assessment enables the clinician to enter details relating to the duration of any convulsion via the **clock symbol** buttons. Additional Free Text fields are also provided to capture data not collected elsewhere.

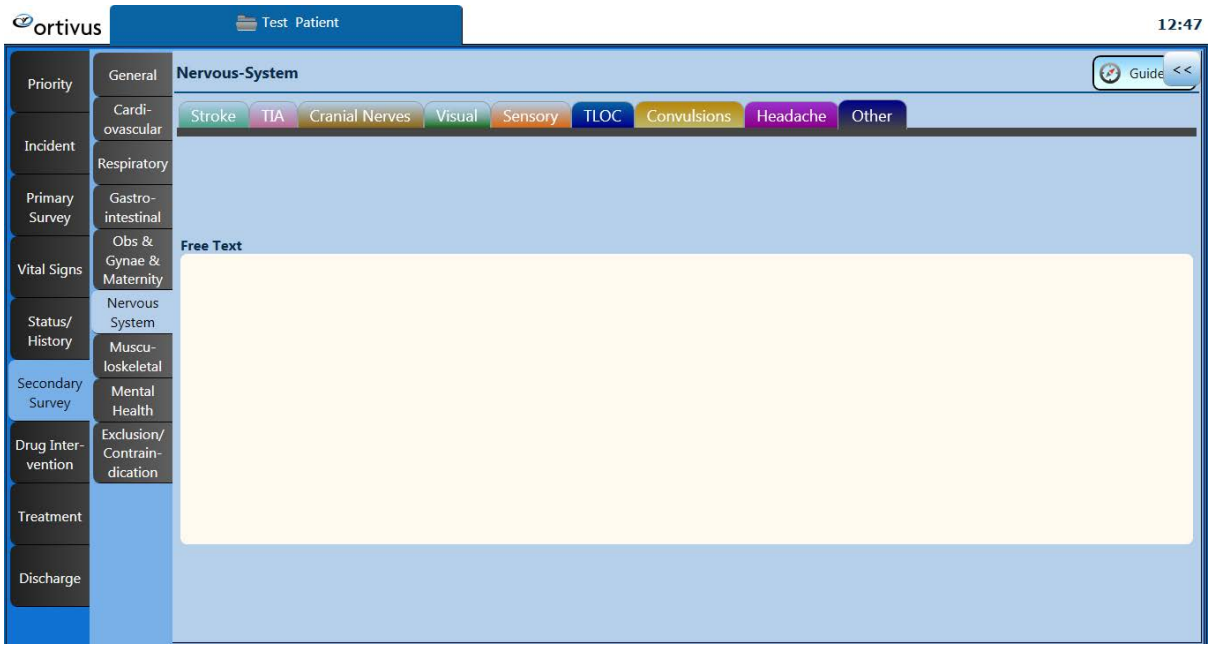


4.6.68 Should the clinician be called to a patient presenting with a **Headache**, various fields are provide to assist the clinician in undertaking a structured assessment. These questions combine Yes, No functionality and also capture duration and a final **Free Text** field to allow for the capture of data not entered elsewhere.

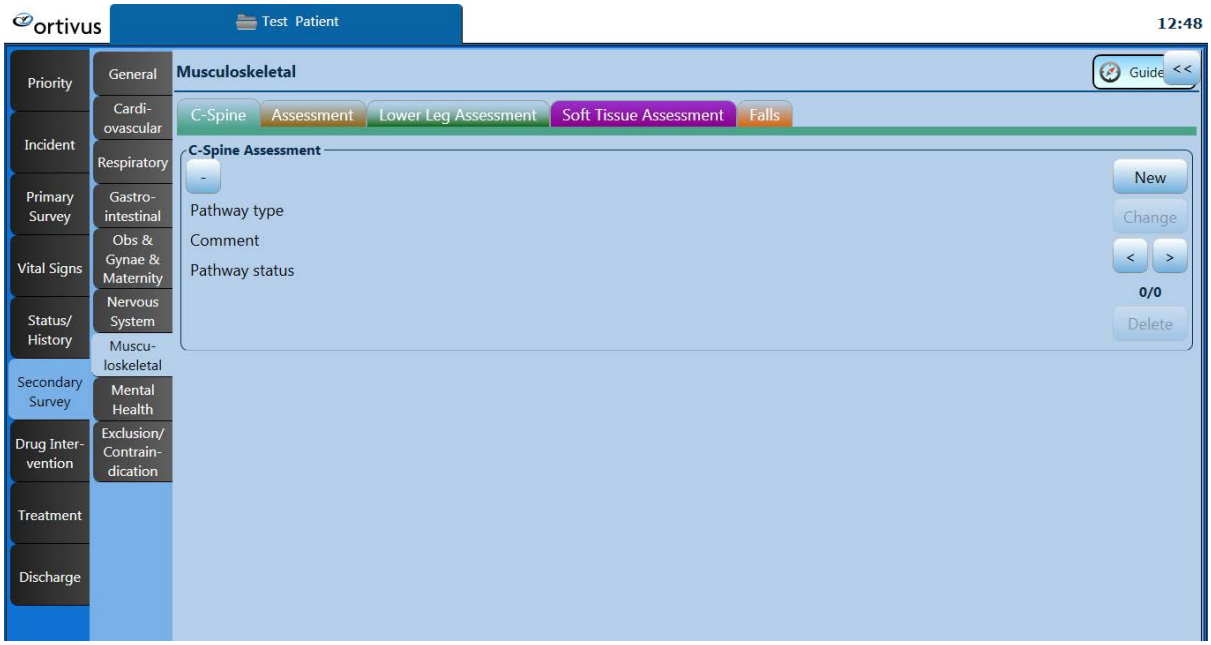
4.6.69 Some questions such as **worst headache ever**, **neck stiffness** may support identification of Meningitis or headache suggestive of cranial bleed and should be considered along with other findings when determining the final care plan.



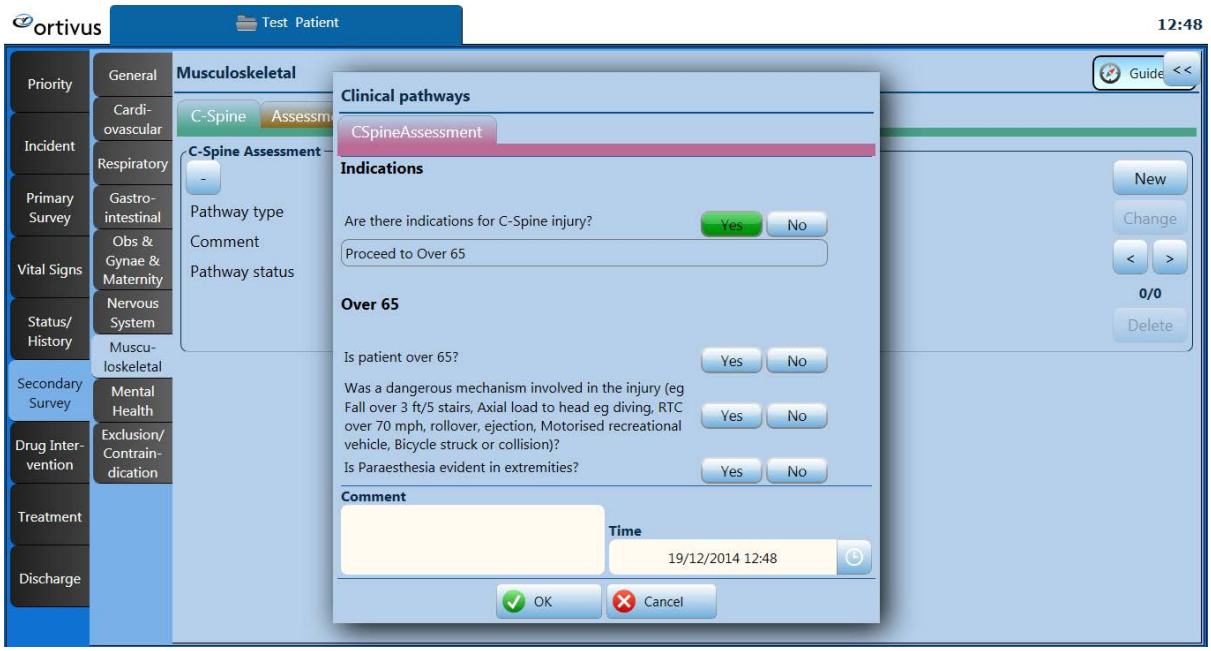
4.6.70 The **Other** screen enables the clinician to capture in a free text format, data relating to the patient neurological status that is not captured elsewhere.



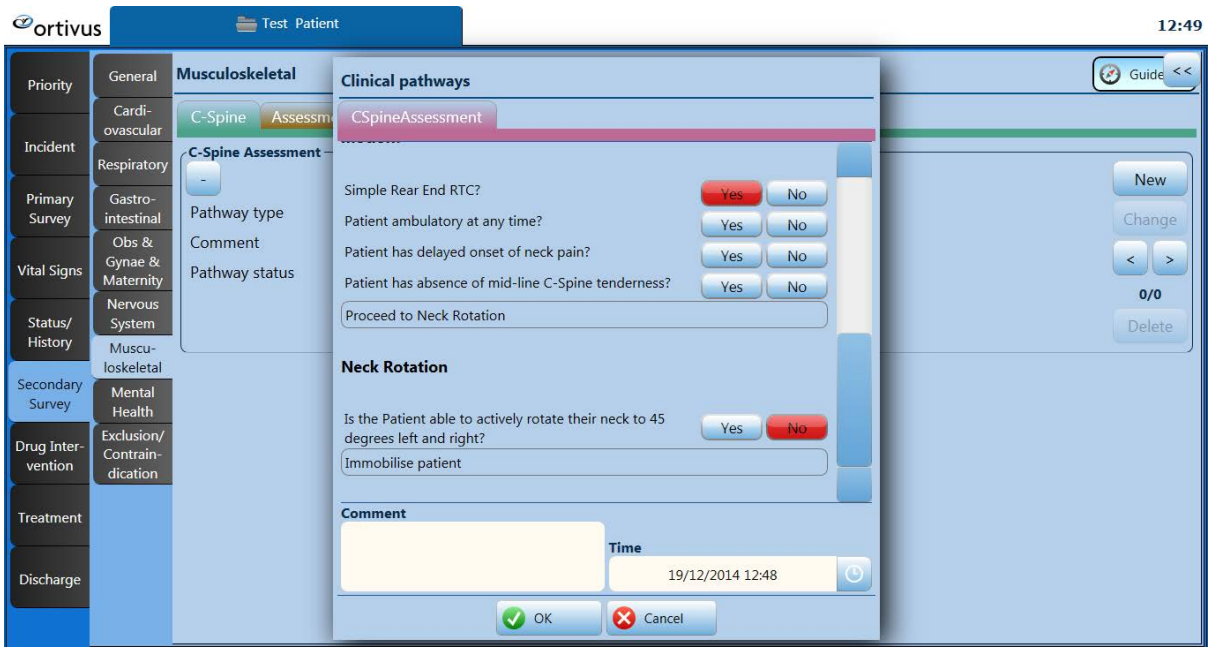
4.6.71 The **Musculoskeletal** screens have a number of tertiary tabs that enable the clinician to document findings associated with a detailed assessment of the patient's musculo-skeletal system. This includes **C Spine**, general **Assessment**, **Lower Leg Assessment**, **Soft Tissue Assessment** and information relating to any patient who has suffered a **Fall**.



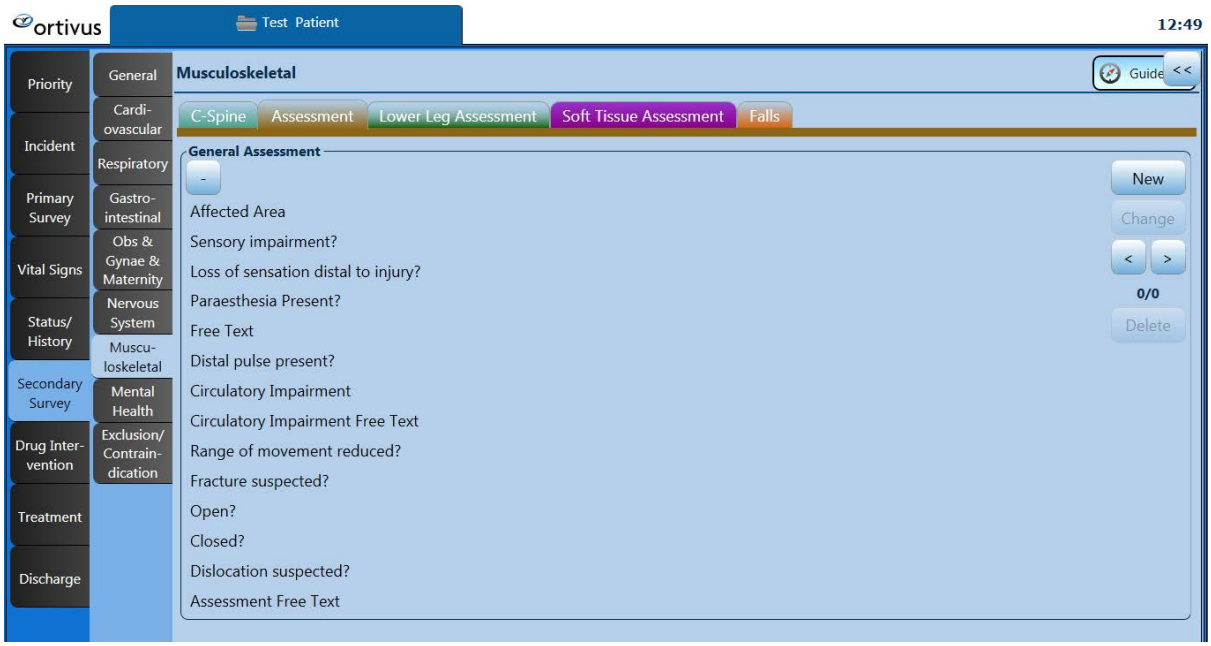
4.6.72 The **C-Spine Assessment**, accessed via the **New** button provides the clinician with an electronic version of the Canadian C Spine tool. This will provide guidance to the clinician to support the decision making process.



4.6.73 The clinician is directed through a series of questions each section dependant on the answers provided in the previous section. The **C-Spine Assessment** will support and document the decision making process prompting the clinician to immobilise the patient based on the Canadian C Spine rules. The functionality also allows for the capture of additional information using the free text Comment field.

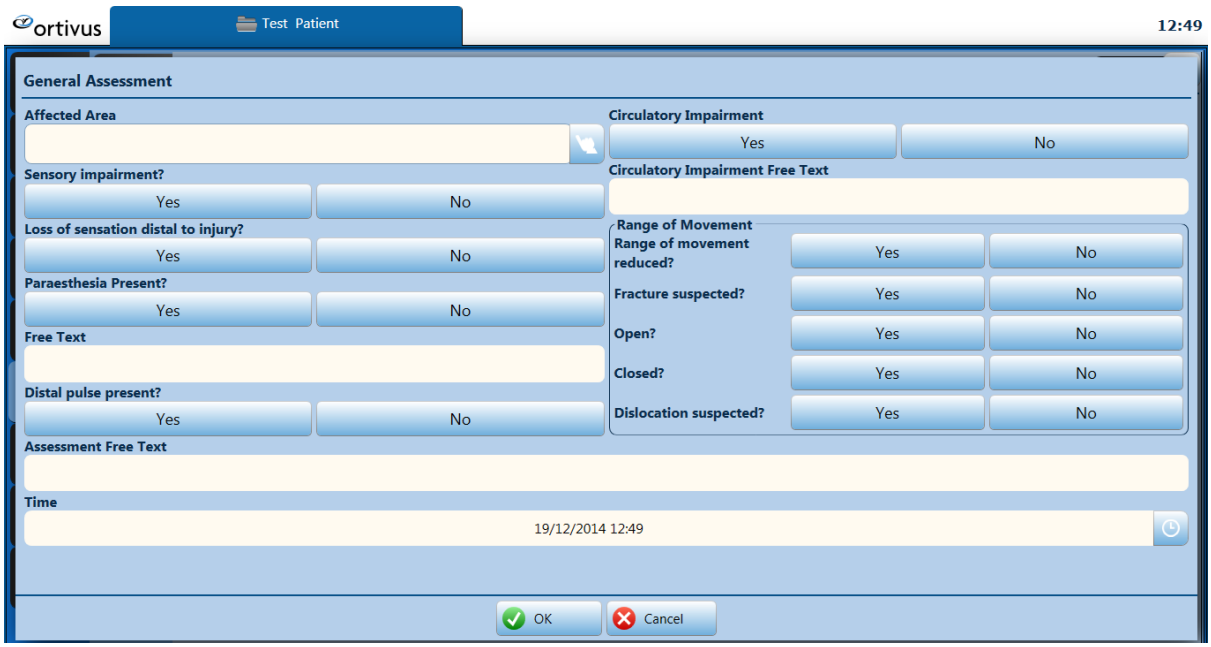


4.6.74 A general musculo-skeletal assessment can be accessed via the **Assessment** tab. To access the data fields the clinician clicks on the **New** button.

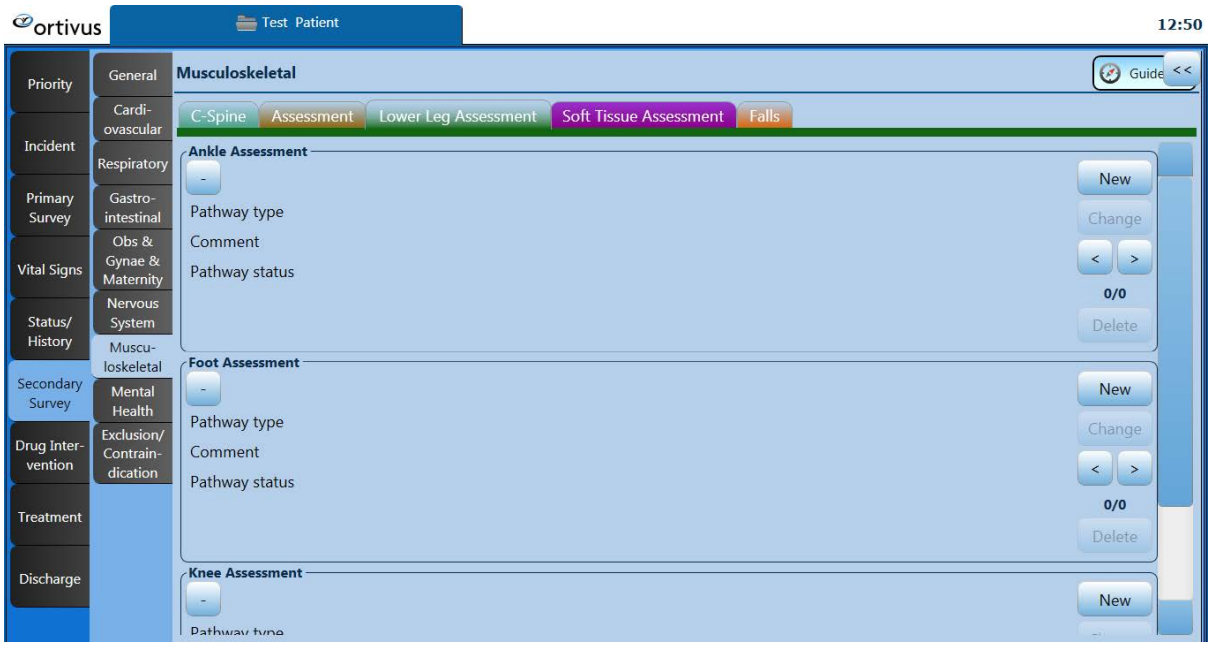


4.6.75 The clinician can select the affected area(s) from a multi select **Affected Area** field by clicking on the **white finger symbol**. Additional information can then be recorded, detailing the **Sensory** and **Circulatory** impact of the injury, along with an assessment of the **Range of Movement**.

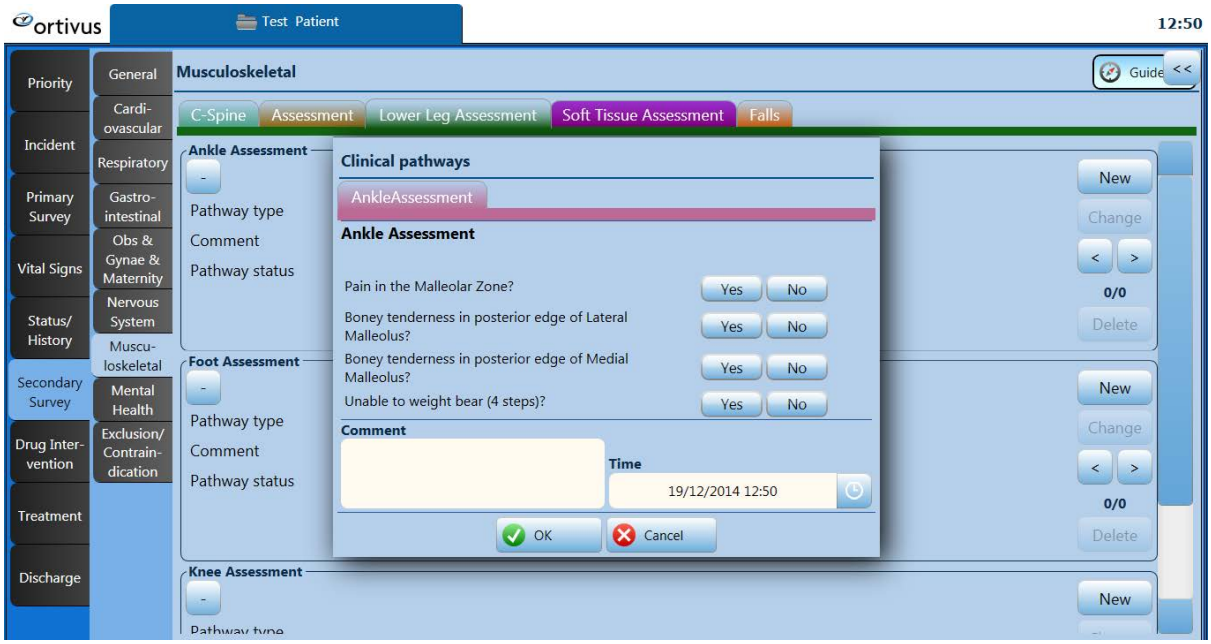
4.6.76 An additional **Assessment Free Text** field is also provided to allow for the capture of any data not entered elsewhere.



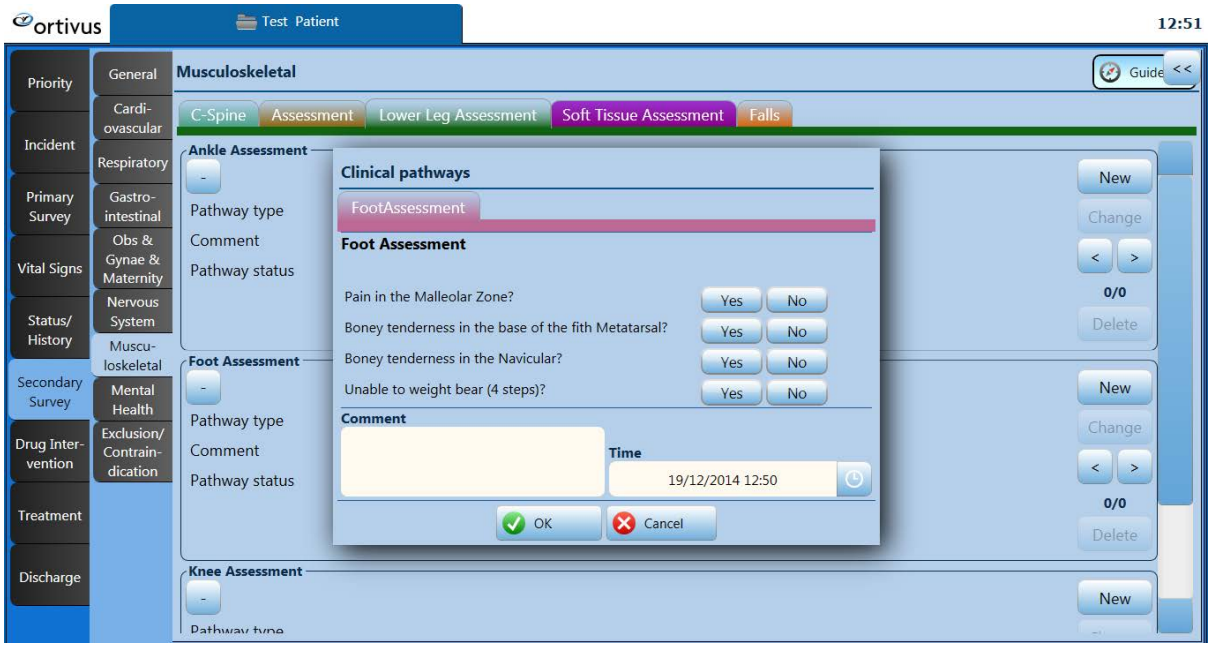
4.6.77 A structured assessment of **Lower Leg Injuries** for **Ankle**, **Foot** and **Knee** are provided by clicking the appropriate **New** button. These assessments help determine whether x-ray would be advised.



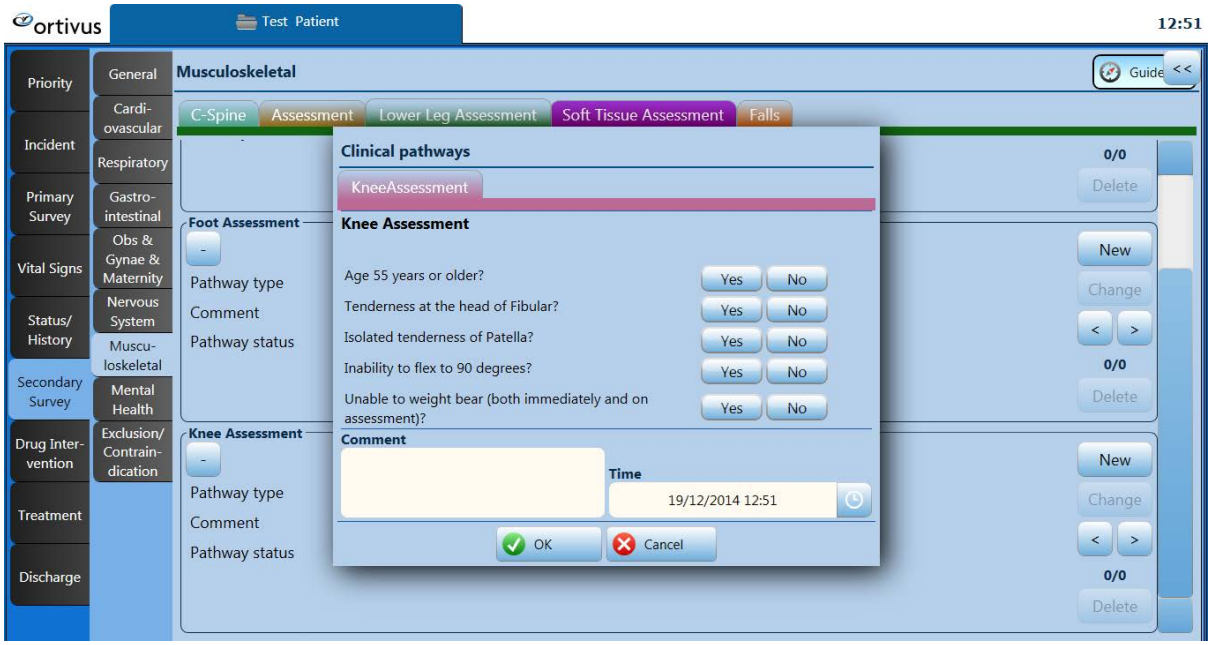
4.6.78 The **Ankle Assessment** provides the clinician with a series of questions, each created to highlight areas of clinical concern. A **Yes** for any of the questions would indicate that an x-ray may be required to rule out boney injury. An additional free text field is available under **Comment** to capture any other findings not captured elsewhere.



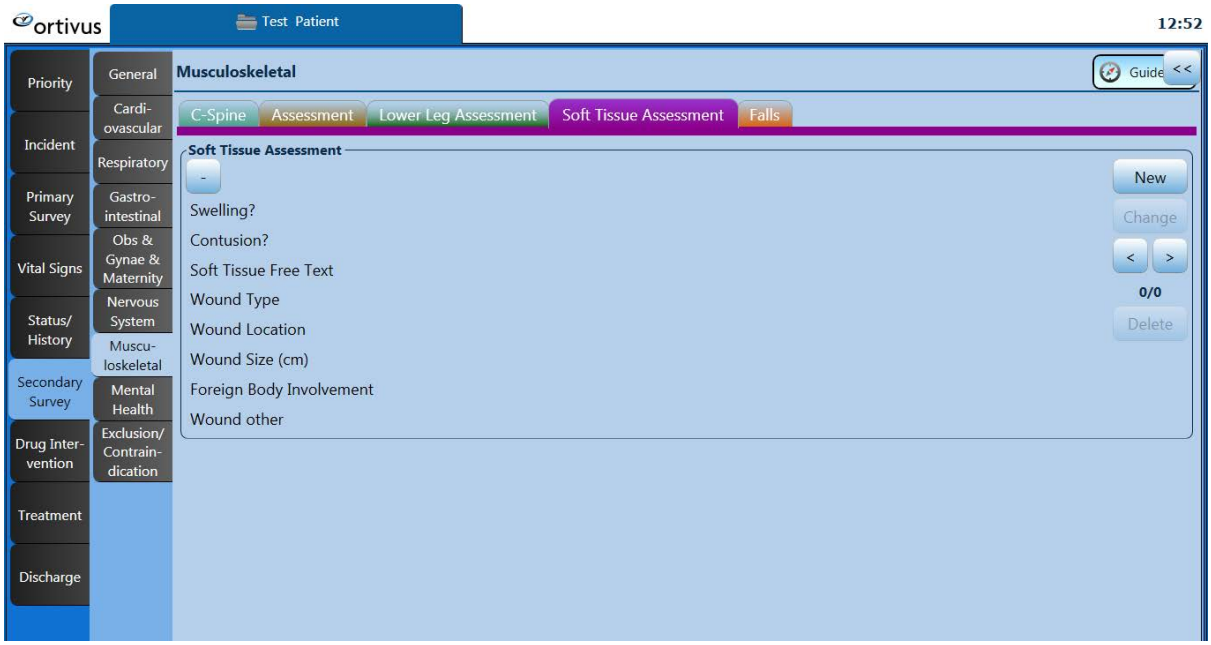
4.6.79 The **Foot Assessment** provides the clinician with a series of questions, each created to highlight areas of clinical concern. A **Yes** for any of the questions would indicate that an x-ray may be required to rule out boney injury. An additional free text field is available under **Comment** to capture any other findings not captured elsewhere.



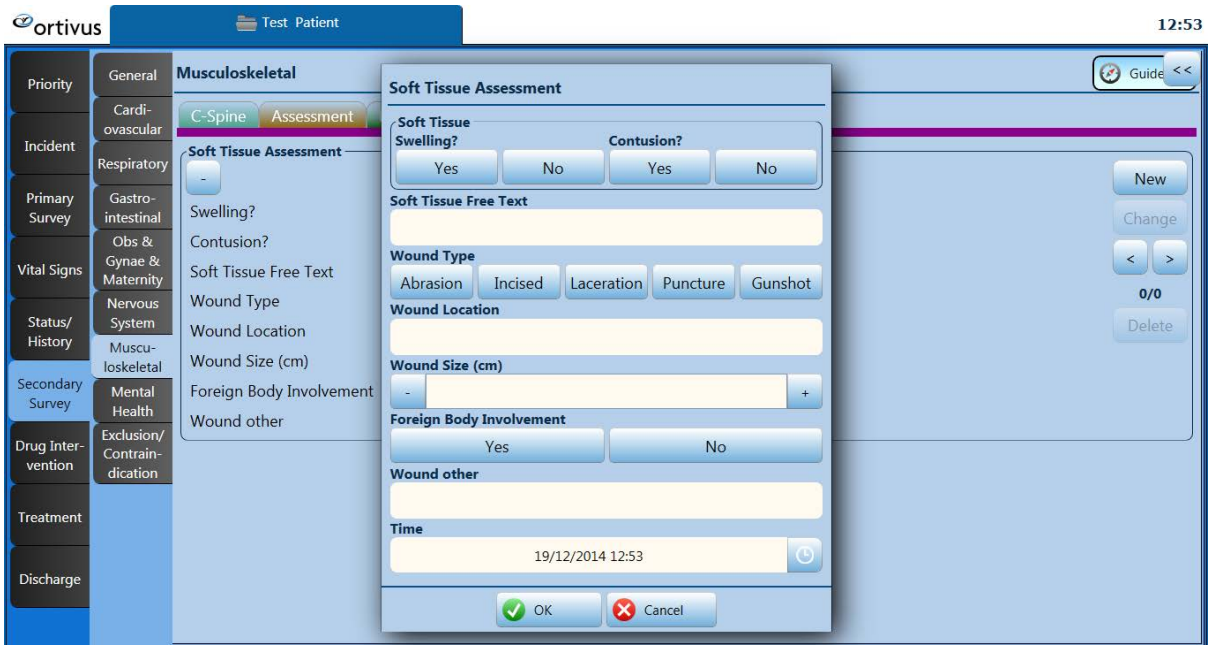
4.6.80 The **Knee Assessment** provides the clinician with a series of questions, each created to highlight areas of clinical concern. A **Yes** for any of the questions would indicate that an x-ray may be required to rule out boney injury. An additional free text field is available under **Comment** to capture any other findings not captured elsewhere.



4.6.81 The **Soft Tissue Assessment** provides the clinician with an opportunity to document the assessment of any soft tissue injuries. The clinician accesses the data fields by clicking the **New** button. Multiple assessments can be entered simply by creating a new assessment by clicking the **New** button to open up the data fields as required.

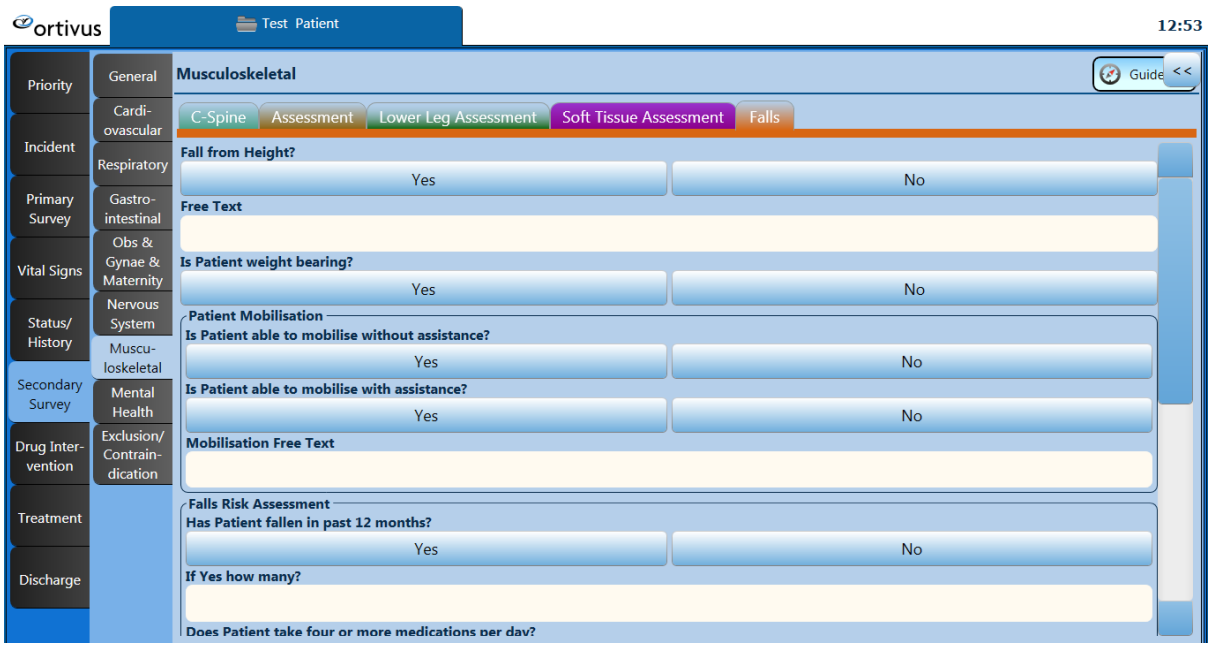


4.6.82 The **Soft Tissue Assessment** captures data relating to **Swelling** and **Contusion**. It also has free text fields to capture details of any **Wounds** and **Foreign Bodies**.

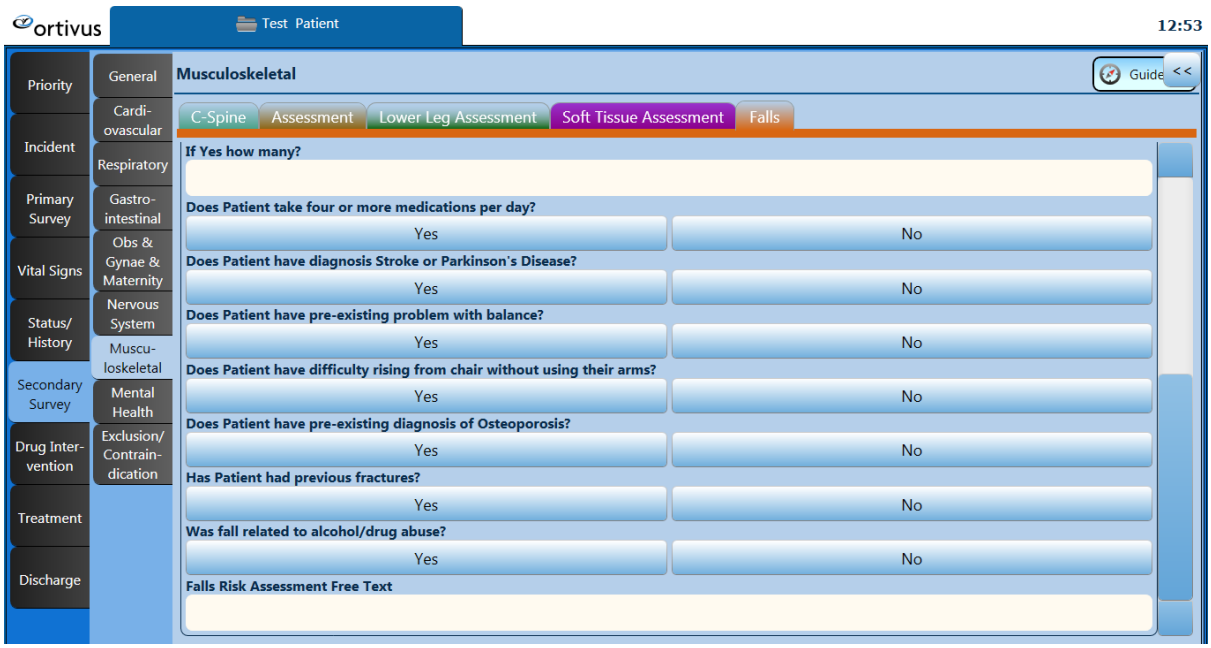


4.6.83 The **Falls** screen enables the clinician to enter details relevant to any patient who has suffered a fall. This includes data fields designed to capture the nature of the **Fall**, whether this has impacted on the patients ability to **Weight Bear** and **Mobilise**.

4.6.84 The Falls screen also captures information relevant to the **Falls Risk Assessment**.



4.6.85 In many areas Falls teams will have referral processes in place to support patients and put in place measures to prevent further falls. Information captured here is used to populate the Falls Referral form and is therefore vital to complete the holistic care for the patient. Data fields are available in Yes, No format and there is also a Falls **Risk Assessment Free Text** field to capture information not provided elsewhere.

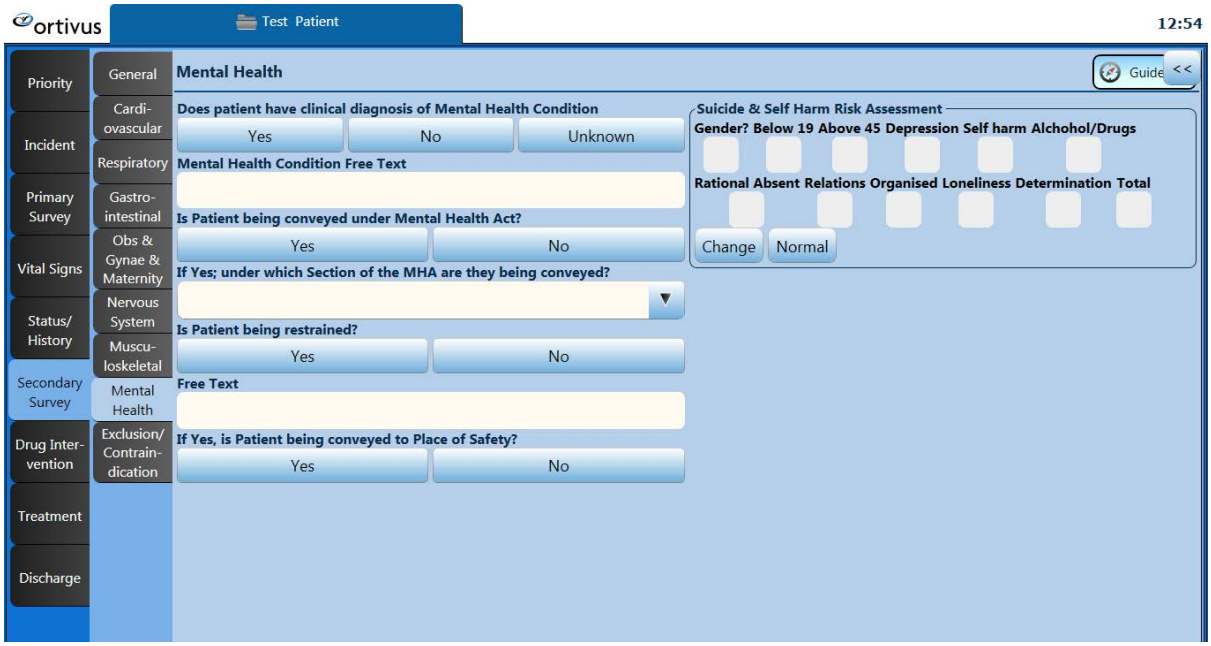


4.6.86 The **Mental Health** screen allows the clinician to enter details for those patients known to have a mental health condition and for those who present with suicide and or self harm.

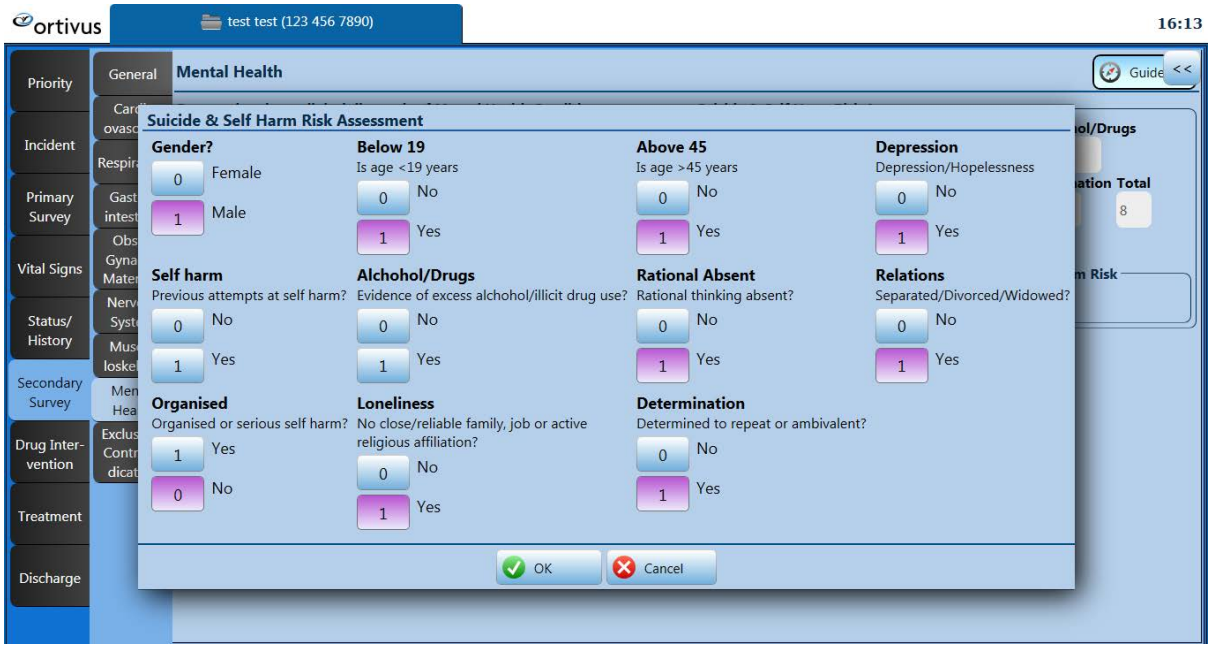
4.6.87 Details of any diagnosed condition can be entered in free text format within the **Mental Health Condition Free Text field**.

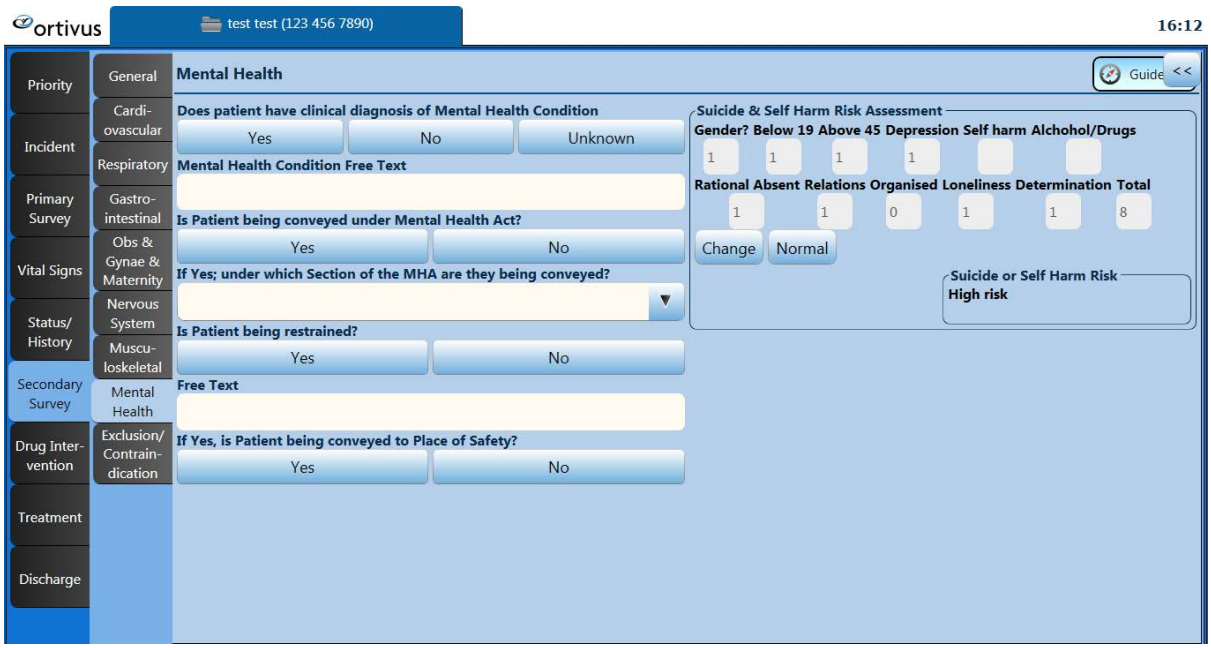
4.6.88 If the patient is being **Restrained**, details of the method used and rationale should be recorded within the appropriate Free Text field.

4.6.89 The **Suicide and Self Harm Risk Assessment** can be accessed by clicking the **Change** button.

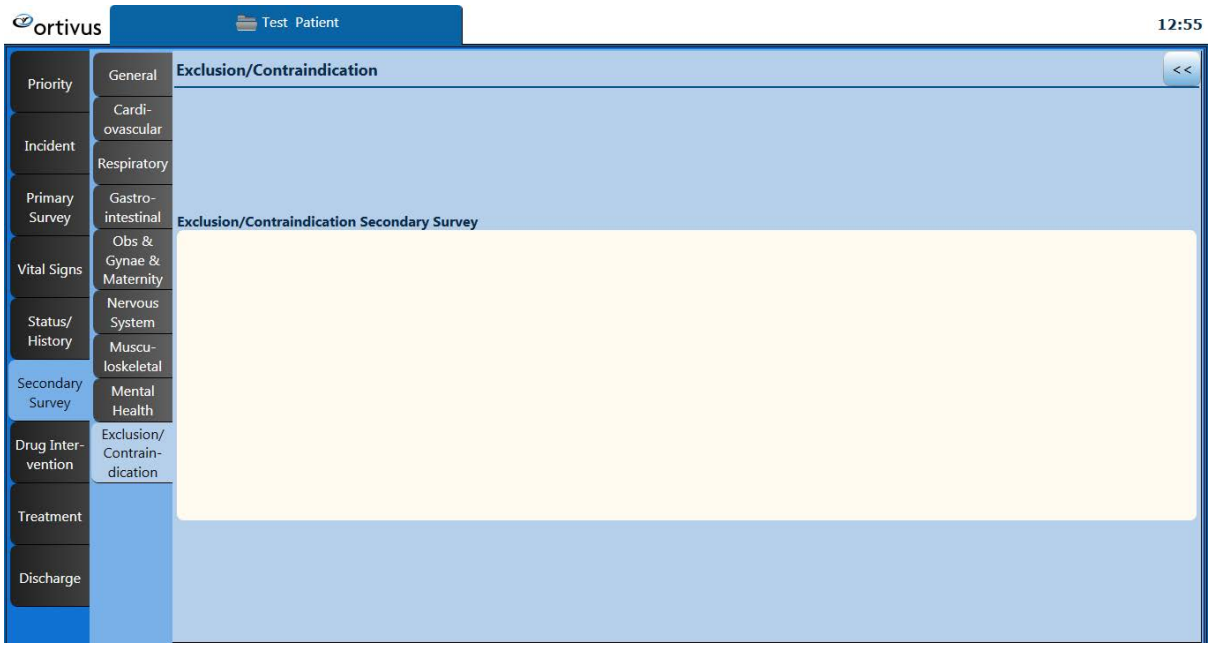


4.6.90 Once opened the **Suicide and Self Harm Risk Assessment** can be used to calculate the relative risk of suicide or self harm. The clinician answers the questions as below and clicks the relevant buttons. Once all questions are answered and **Ok** is clicked the relative risk is displayed.





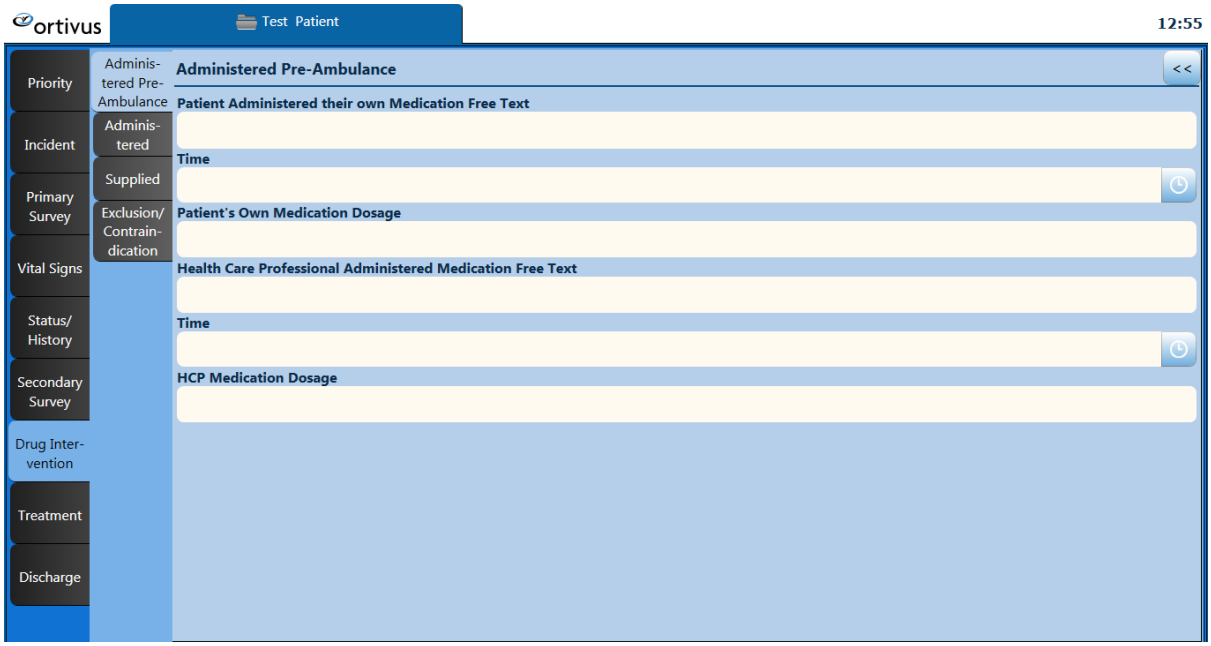
4.6.91 The **Exclusion/Contraindication** screen enables the clinician to enter details of any deviation from guidelines or contraindication in free text format.



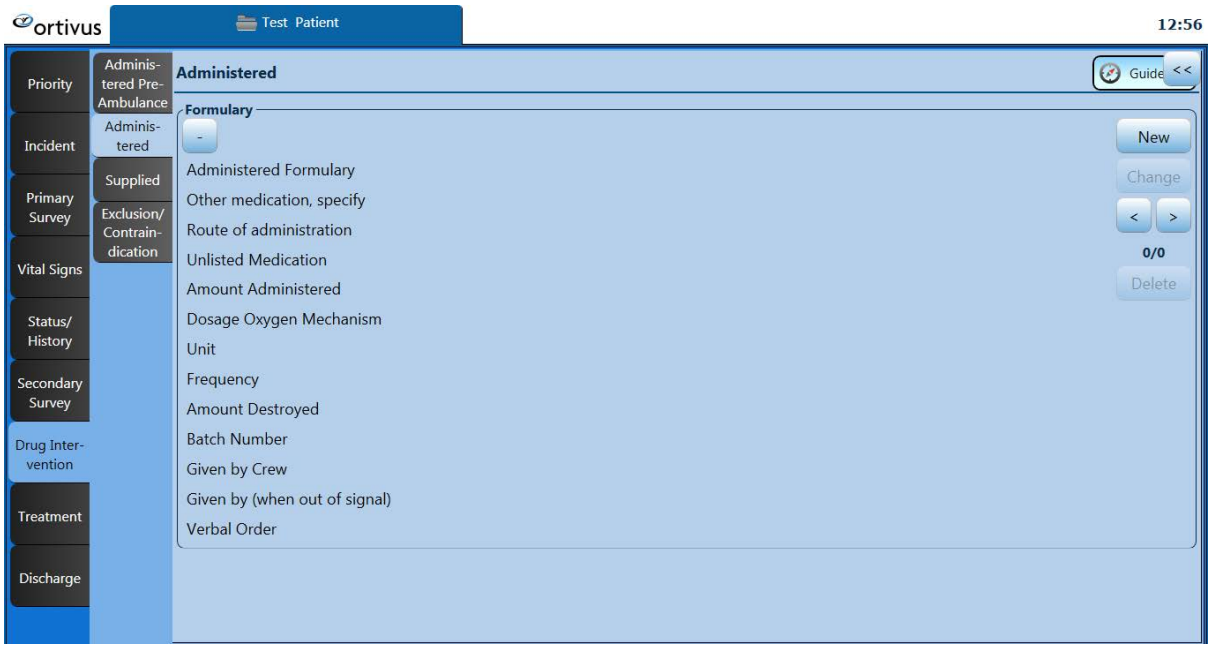
4.7 Primary Tab – Drug Intervention

4.7.1 Administered Pre-Ambulance

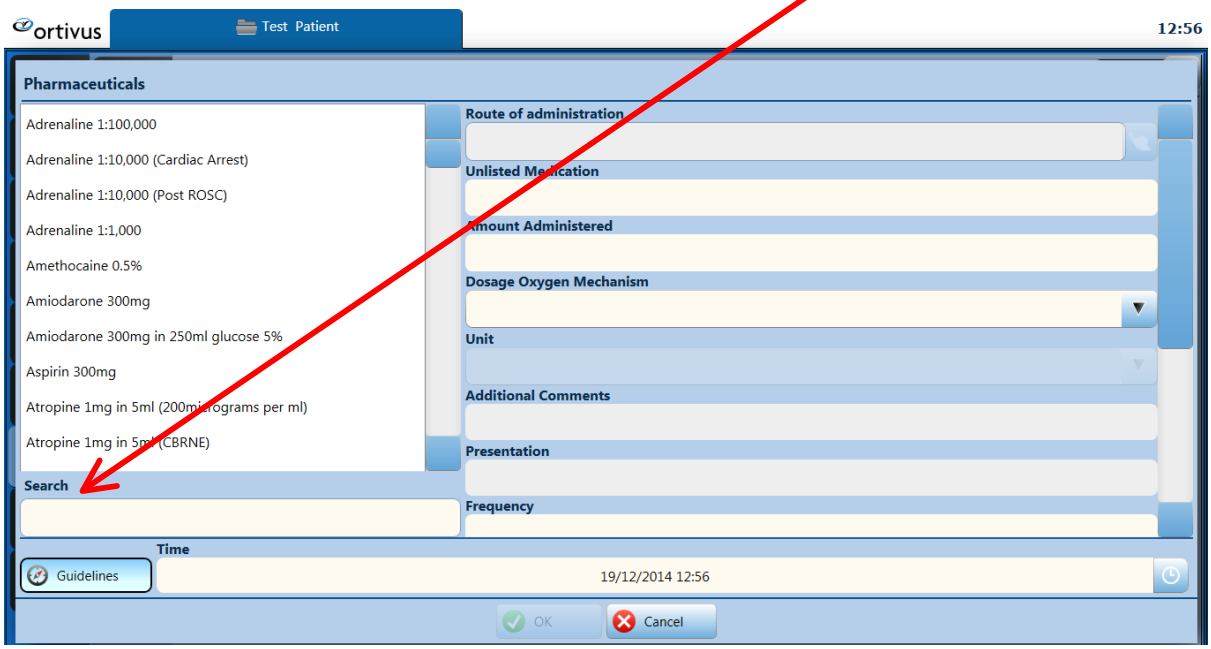
4.7.2 The Administered Pre Ambulance screen enables the clinician to enter details of any medications that the patient has taken prior to ambulance arrival. This may be as a result of the **Patient Administered their own Medication** in free text format, or as a result of a **Health Care Professional Administered Medication** in free text format. This would include over the counter medications alongside prescribed medications such as GTN.



4.7.3 The administration of multiple medications can be captured by clicking on the **New** button for each medication administered by the ambulance clinician.



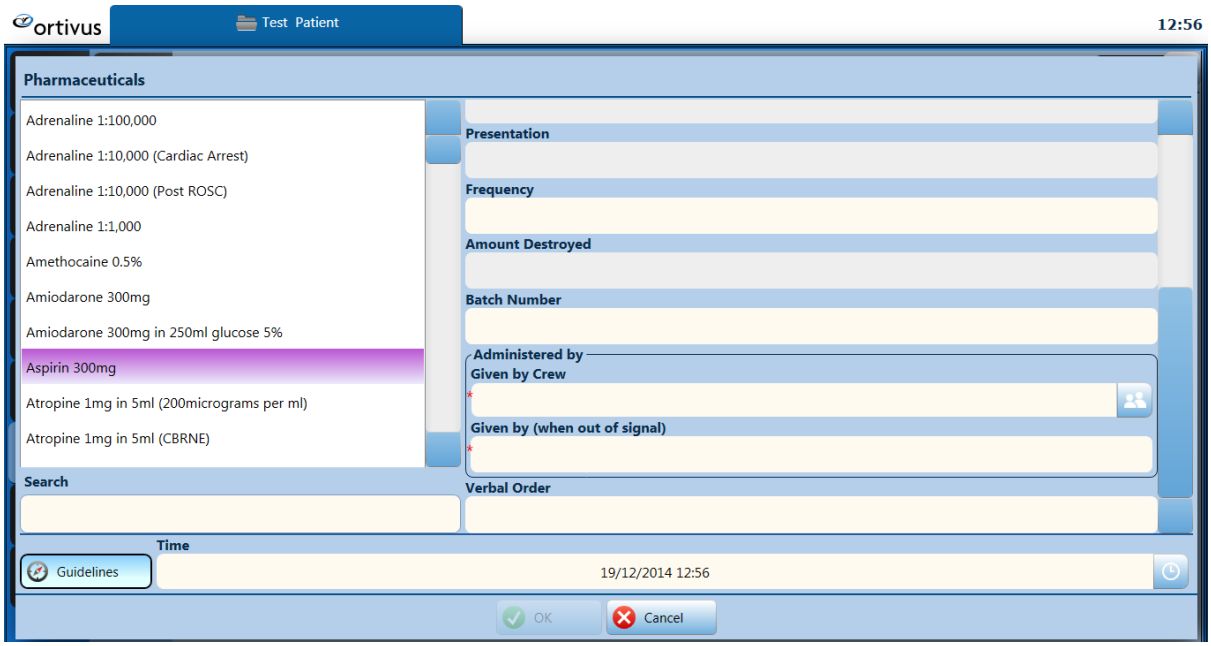
4.7.4 The clinician can either scroll down the alphabetical list of ambulance medications or enter the drug or partial name in the **Search** field.



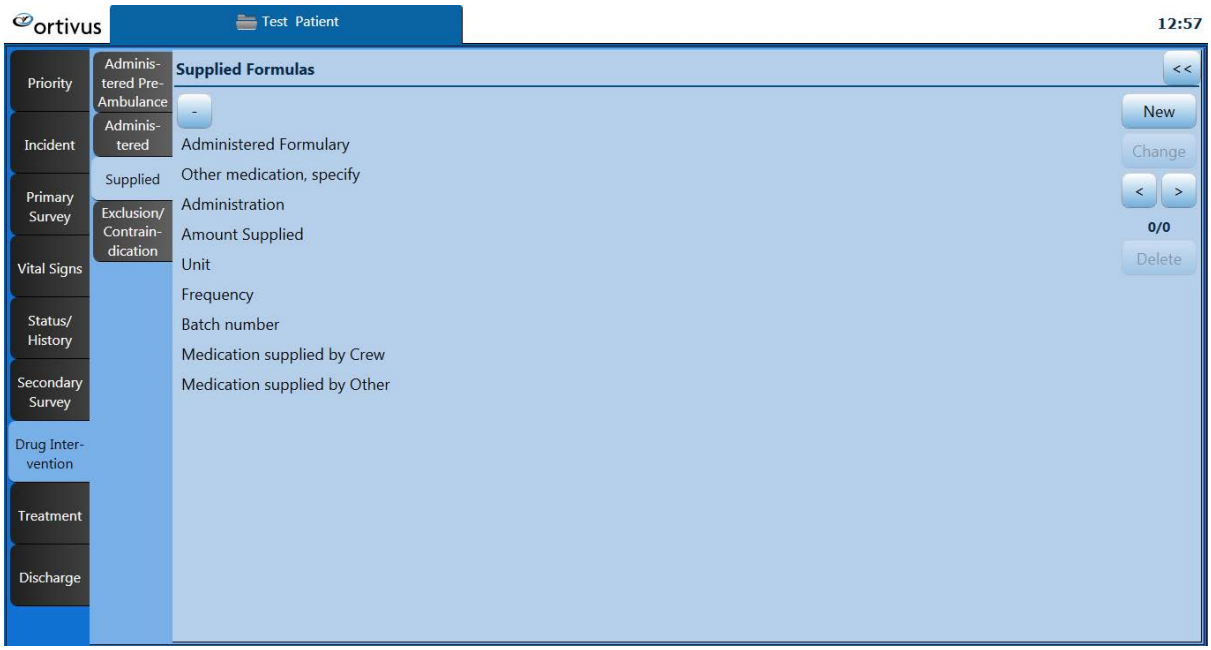
4.7.5 Once the medication is selected, other data fields for route of administration, dosage and unit etc will pre-populate. **These fields can be overridden and pre-populate to support the clinician only. Any medication where a dose range can be given will pre-populate with the lowest dosage**.

4.7.6 The clinician must complete the **Administered** by section to comply with the legal requirement for all medication administrations to be authorised. When not in signal the clinicians 8 digit pin number must be entered in the **Given by (when out of signal)** field.

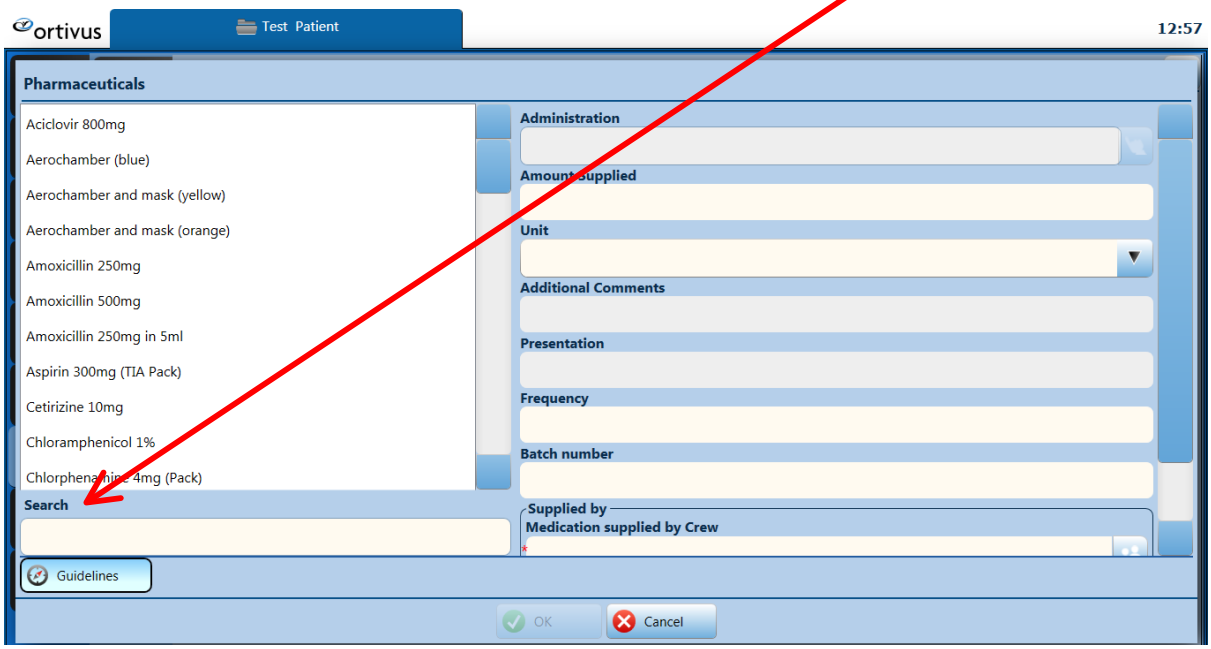
4.7.7 Should the clinician accept a **Verbal Order** for any medication (bearing in mind that no verbal order can be accepted for controlled drugs), a free text field is provided for details of the prescribing clinician who is providing authority for the administration.



4.7.8 Should the clinician be supplying rather than administering any medication, the supply of multiple medications can be captured by clicking on the **New** button for each medication **Supplied** by the ambulance clinician.

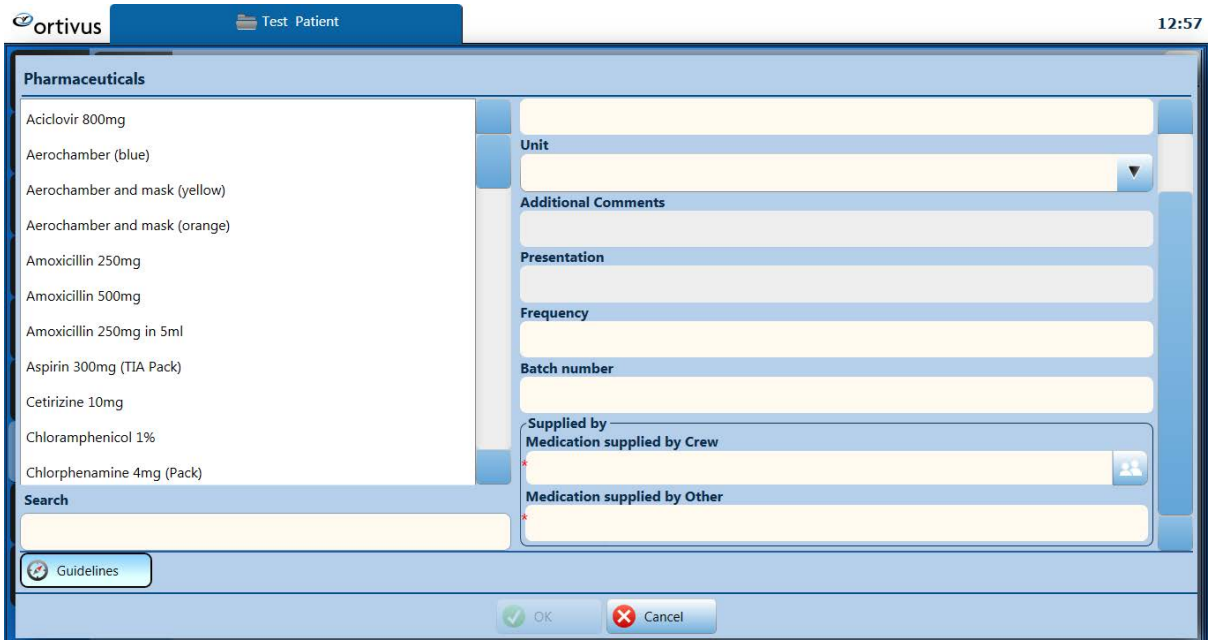


4.7.9 The clinician can either scroll down the alphabetical list of ambulance medications or enter the drug or partial name in the **Search** field.



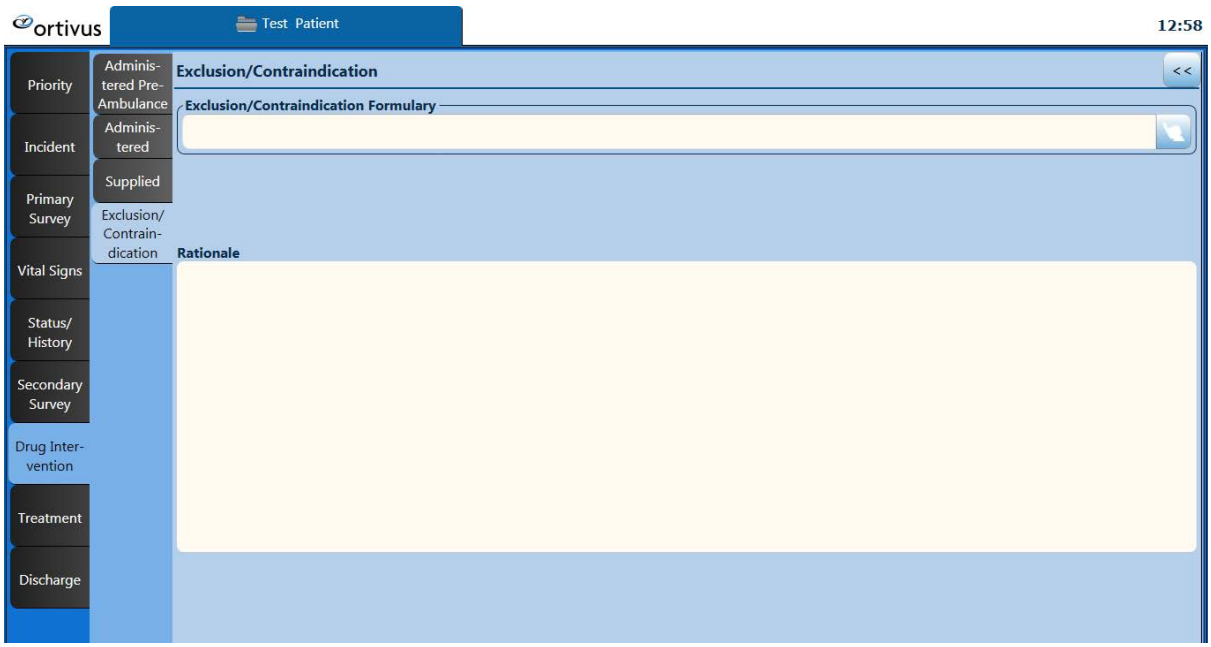
4.7.10 Once the medication is selected, other data fields for route of administration, dosage and unit etc will pre-populate. **These fields can be overridden and pre-populate to support the clinician only. Any medication where a dose range can be given will pre-populate with the lowest dosage**.

4.7.11 The clinician must complete the **Supplied** by section to comply with the legal requirement for all supplied medication to be authorised. When not in signal the clinicians 8 digit pin number must be entered in the **Medication supplied by Other** field.



4.7.12 The **Exclusion/Contraindication** screen enables the clinician to enter details of any deviation from guidelines with regards medication.

4.7.13 The clinician can select a drop down list of medications using the **white finger symbol**. The clinician can then enter the **Rationale** for deviation or provide details of any exclusion or contraindication in free text format.

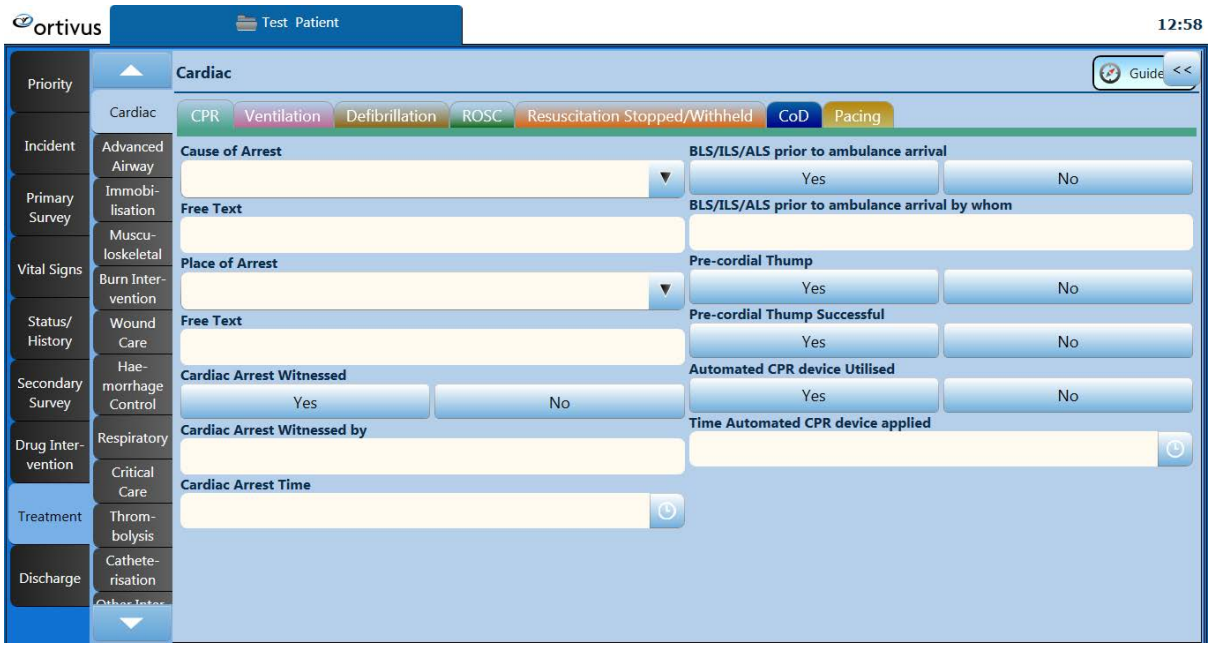


4.8 Primary Tab – Treatment

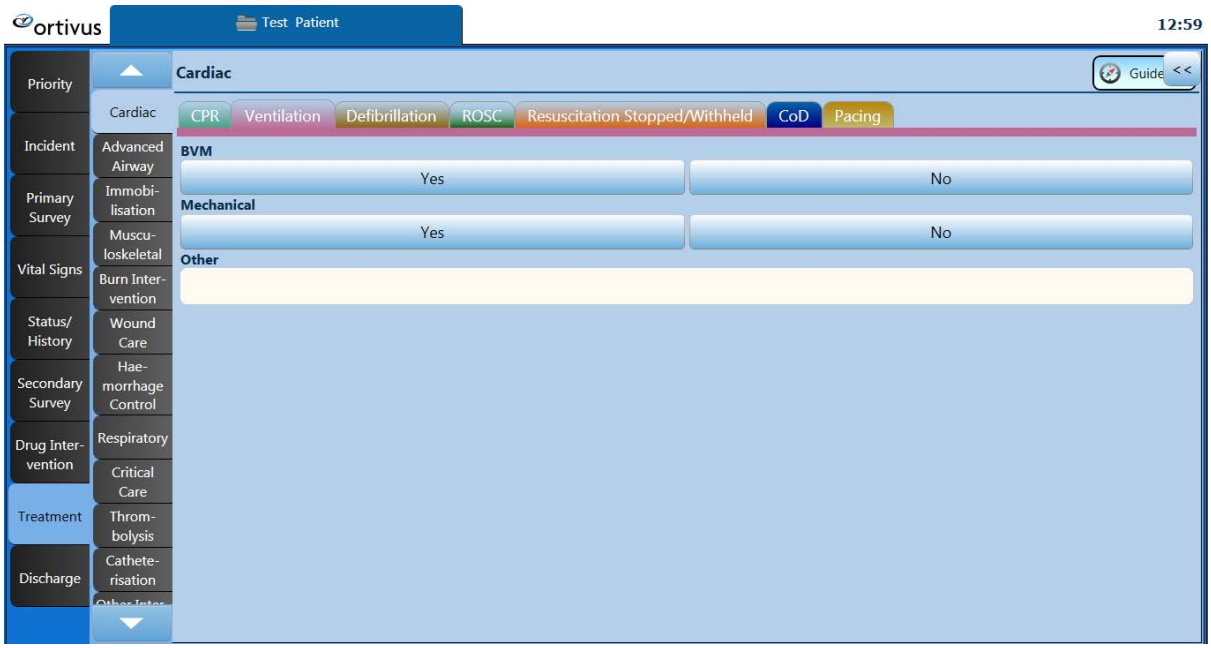
4.8.1 Cardiac Screen

4.8.2 The **Cardiac** screen has a number of tertiary tabs which enable the clinician to capture details of any clinical intervention or treatment relating to cardiac events. These include **CPR** (Cardio-Pulmonary Resuscitation), **Ventilation**, **Defibrillation**, **ROSC** (Return of Spontaneous Circulation), **Resuscitation Stopped/Withheld**, **CoD** (Confirmation of Death) and **Pacing**.

4.8.3 The **CPR** screen enables the clinician to enter information relating to the management of a cardiac arrest. This screen combines drop down lists accessed via the down arrow button, simple **Yes**, **No** functionality, time fields and additional free text fields.

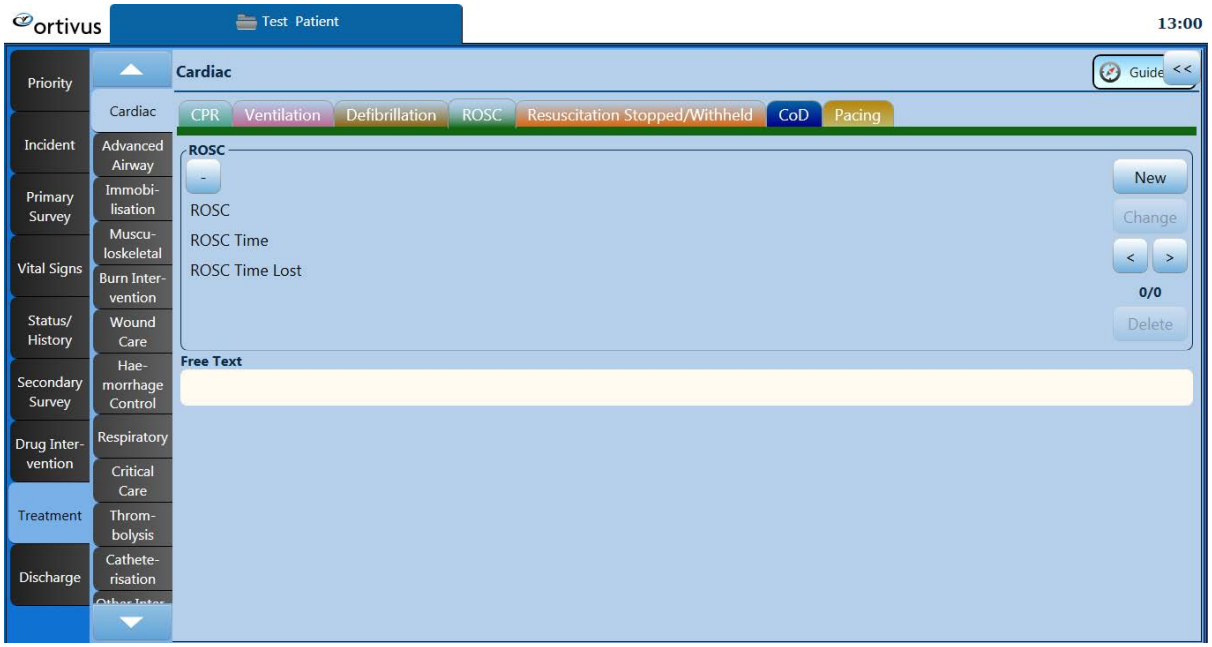


4.8.4 The **Ventilation** screen captures information relating to the use of **BVM** (Bag Valve Mask and or any other **Mechanical** ventilator.

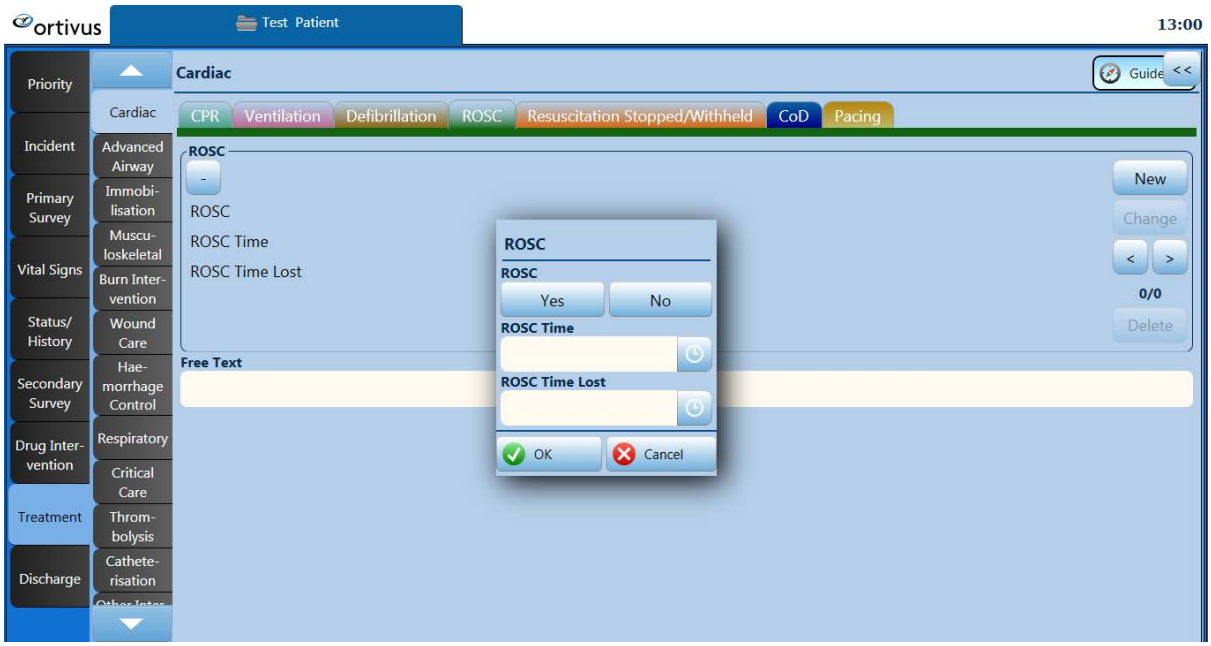


4.8.5 The **Defibrillation** screen captures information relating to the **Initial Arrest Rhythm** via drop down list and further details relating to the use of defibrillation, including number of shocks and associated timings.

4.8.6 The **RoSC** or Return of Spontaneous Circulation screen allows the clinician to enter whether RoSC has been achieved and whether it was subsequently lost or regained. An additional **Free Text** field is provided to capture any information relevant to the loss or capture of RoSC outside of initial timings. The clinician clicks on **New** to open the RoSC timings screen.

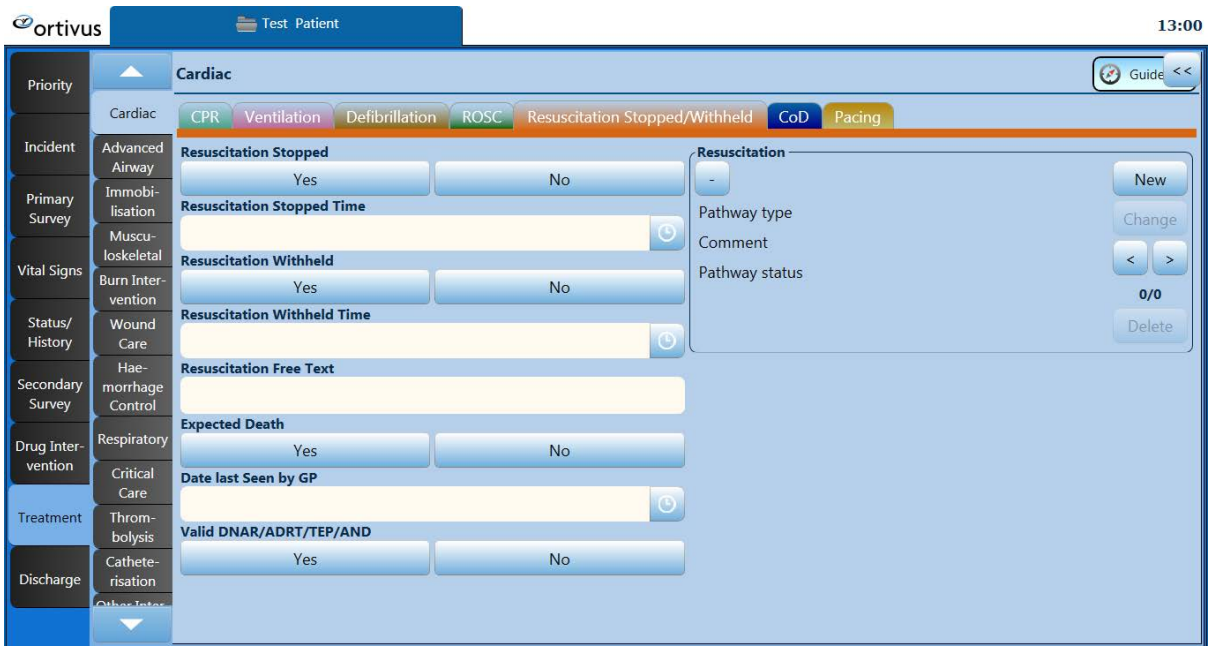


4.8.7 Once the RoSc screen is open the clinician uses the relevant time fields to capture **RoSc Time** and **Time Lost**.

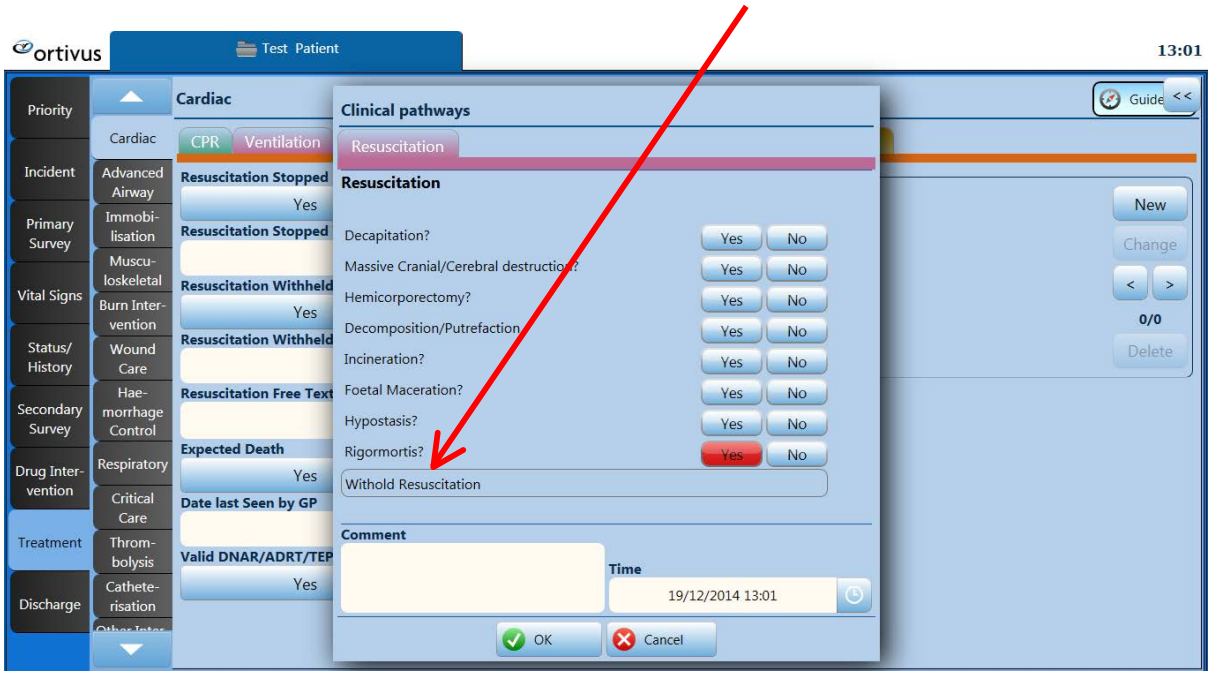


4.8.8 The **Resuscitation Stopped/Withheld** screen captures data relevant to the cessation of resuscitative efforts. Most data fields are simple Yes, No or Time capture fields.

4.8.9 The **Resuscitation** Box allows the clinician to document information related to the requirement to withhold or continue resuscitation. The clinician clicks on the **New** button to open this tool.

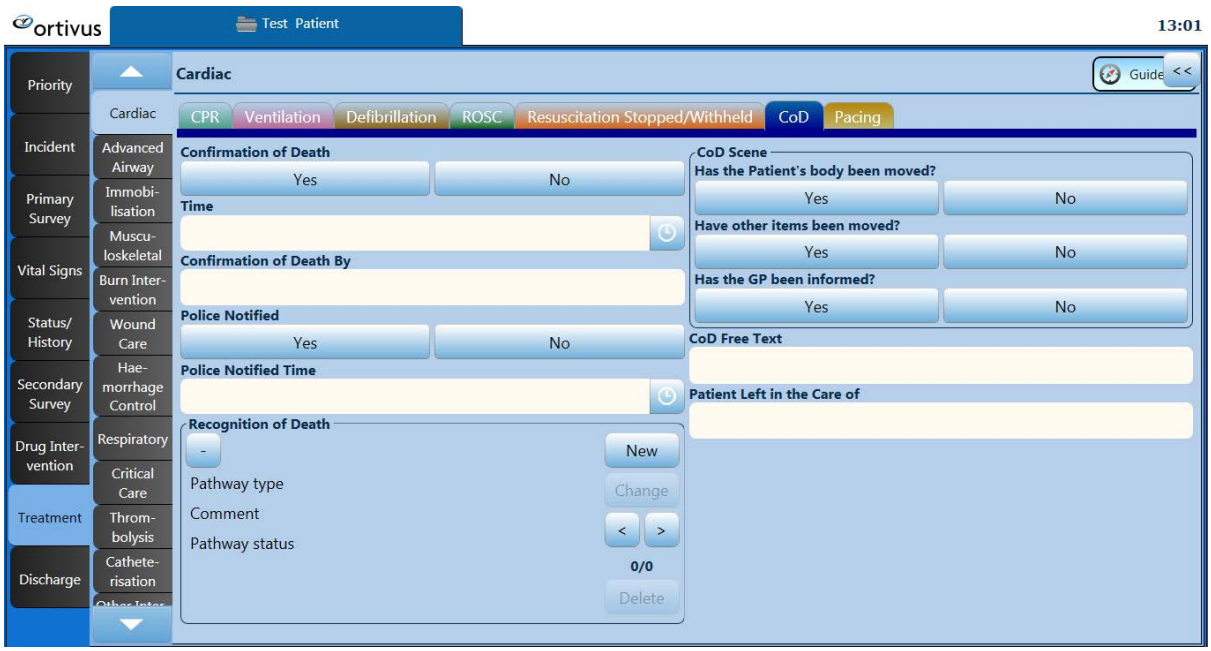


4.8.10 The **Resuscitation** box provides the clinician with a list of questions with **Yes**, **No** answers, any **Yes** would constitute a sufficient rationale to withhold resuscitation and this will be displayed as below.

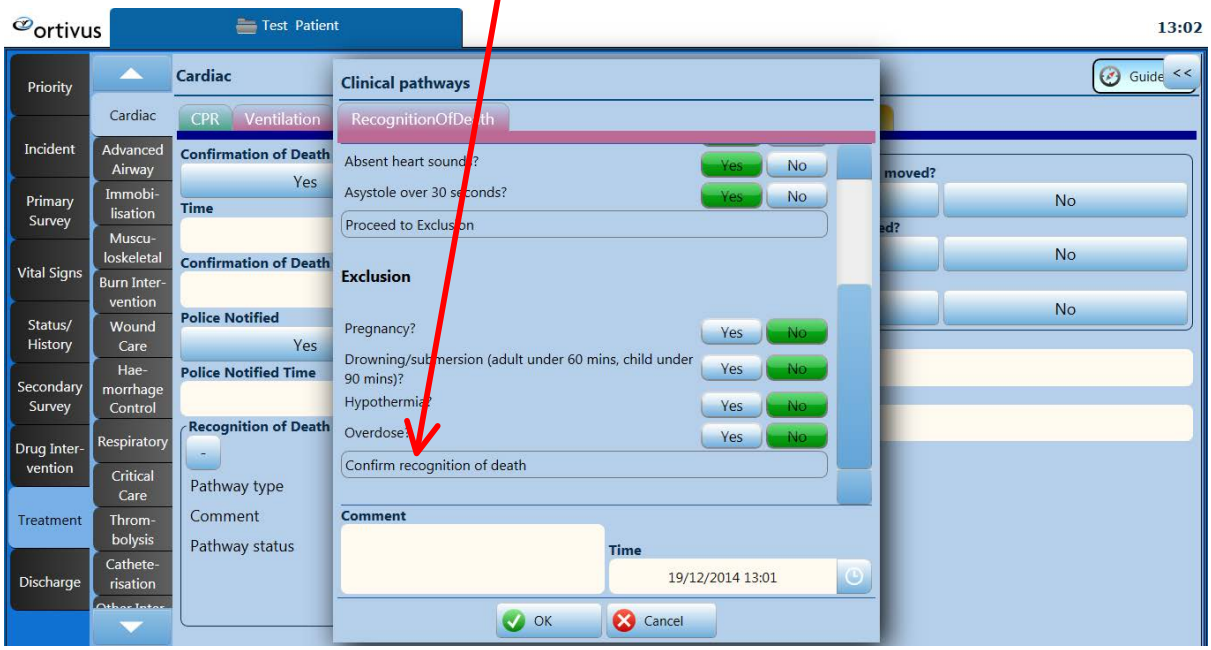


4.8.11 The **CoD** or Confirmation of Death screen enables the clinician to capture details relevant to the verification or Confirmation of Death.

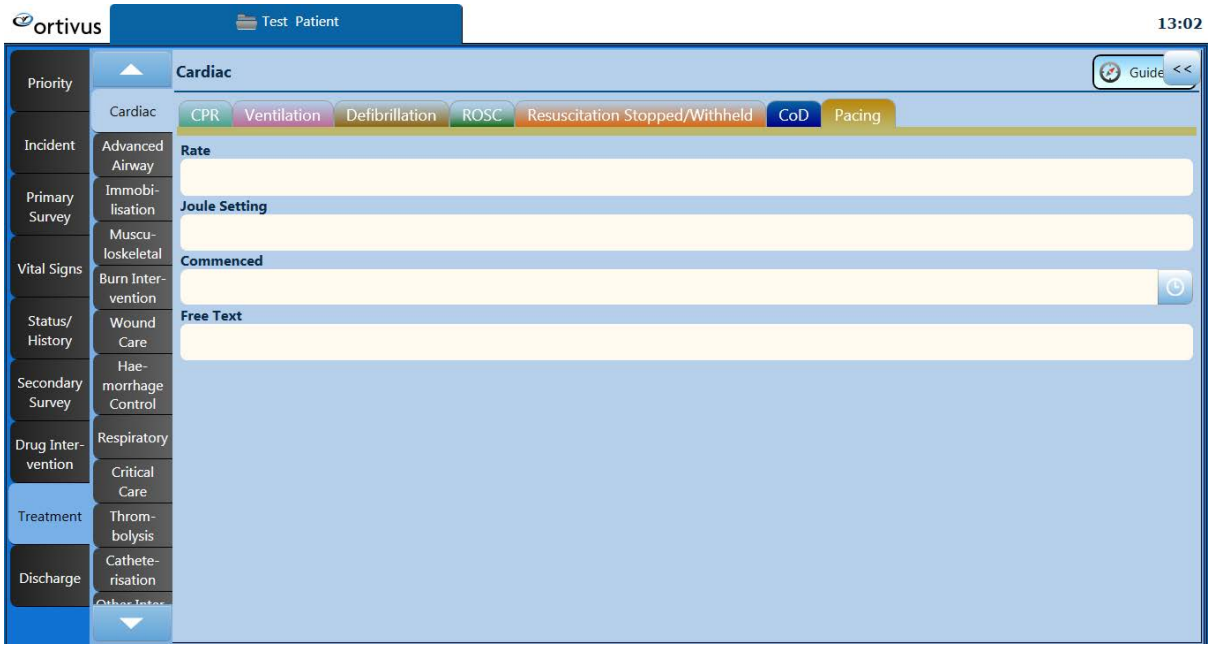
4.8.12 Data fields are provide to capture the time of confirmation and the clinician who has verified the death. Data fields are also provided to ensure that details of the scene in relation to the patients body and or possessions can be captured, either in **Yes**, **No** format or in the **CoD Free Text** field provided.



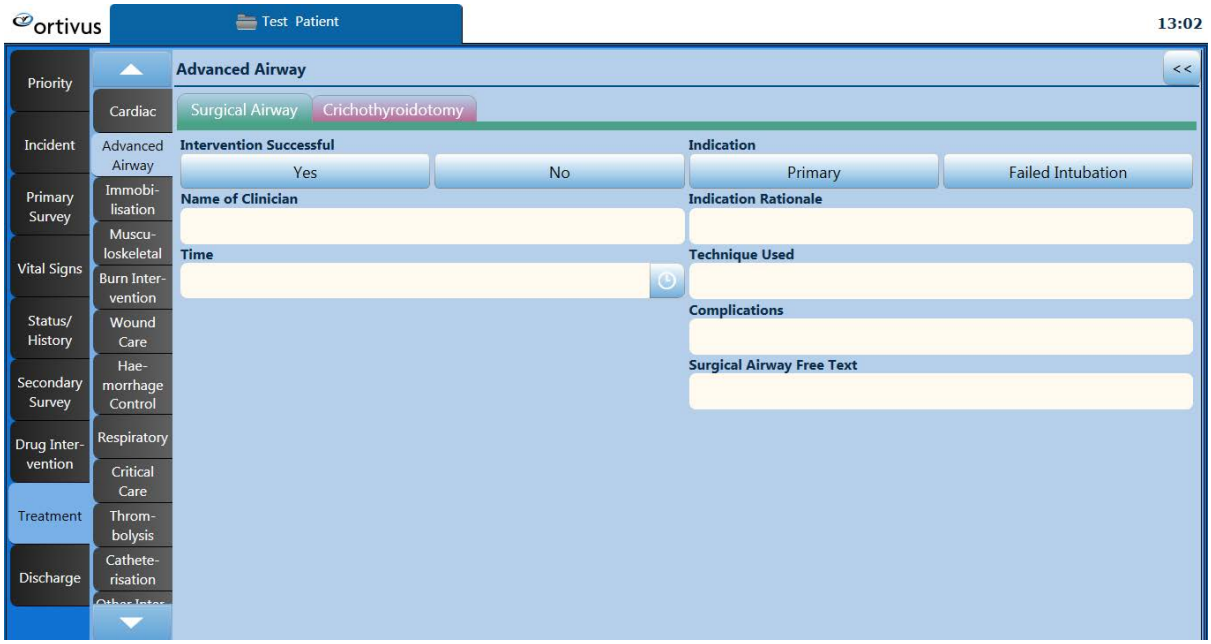
4.8.13 In order to confirm death the clinician must click on the **New** button within the **Recognition of Death** box and work through the checklist provided. The clinician will be taken through the required questions and exclusions for confirmation prior to being given confirmation or otherwise.



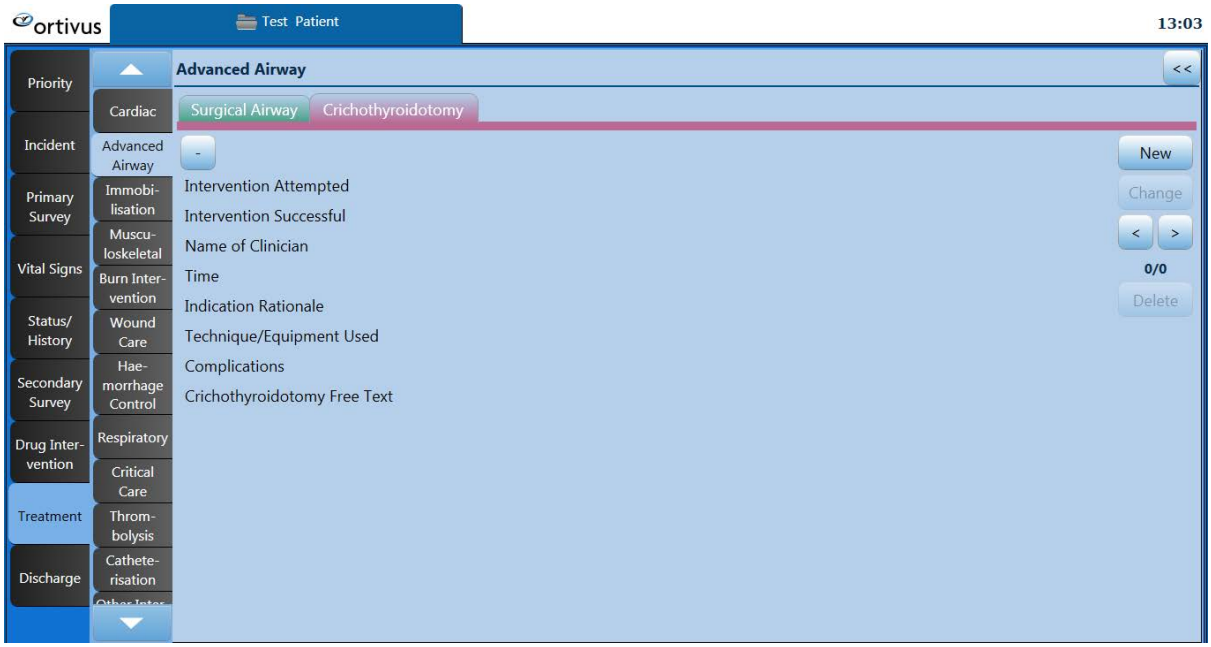
4.8.14 Should the clinician be able to carry out **Pacing**, this screen allows for the capture of information relating to the **Rate**, **Joule Setting** and **Time Commenced**. A **Free Text** field is also available which can be used for the captured of rationale, complications etc.



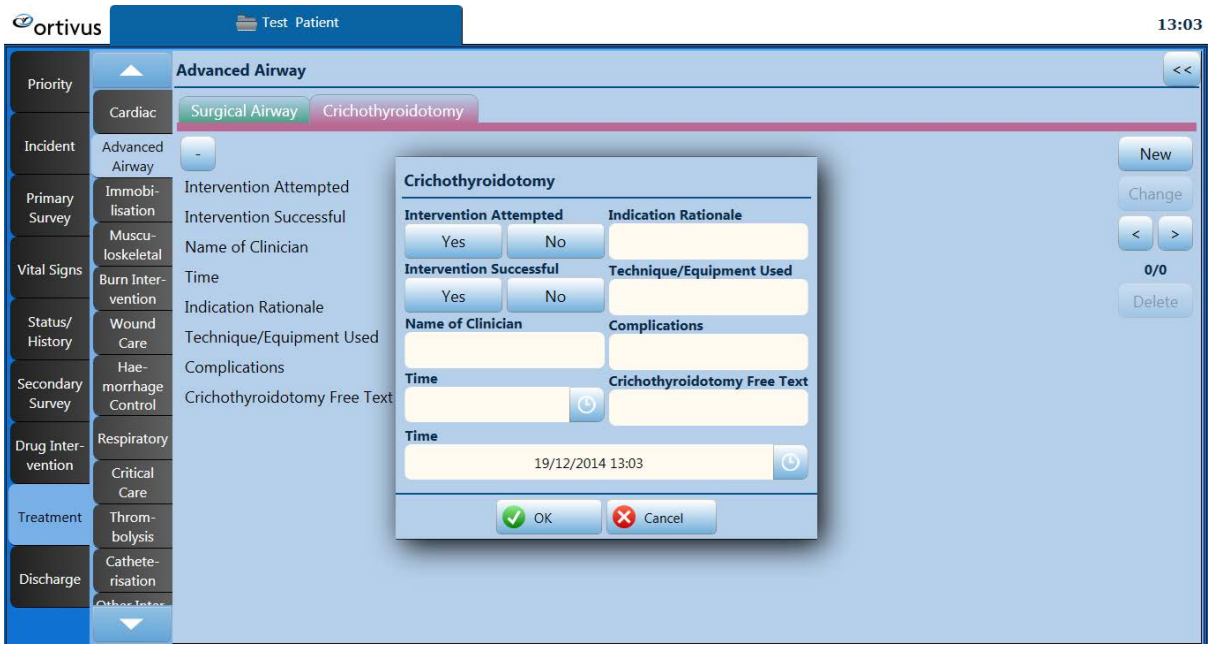
4.8.15 Should the clinician be trained and competent in the use of surgical airway intervention and wish to record this, the **Surgical Airway** screen has a number of data fields, many of which are in free text format to capture the intervention, **Name of Clinician** performing this and details of **Rationale**, **Technique** and **Complications**.



4.8.16 Should the clinician be trained and competent in the use of needle Crichothyroidotomy intervention and wish to record this, the **Crichothyroidotomy** screen can be used to capture this data. The clinician clicks on the **New** button to enter the date fields.

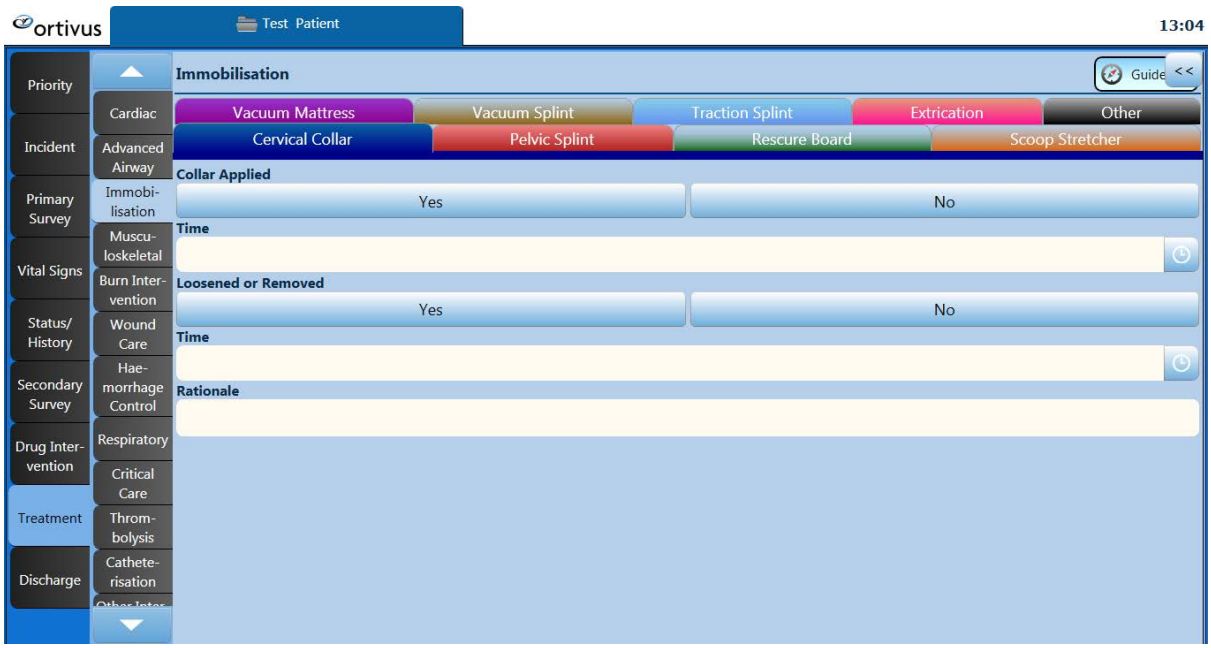


4.8.17 The **Crichothyroidotomy** screen has a number of data fields, many of which are in free text format to capture the intervention, **Name of Clinician** performing this and details of **Rationale**, **Technique** and **Complications**.

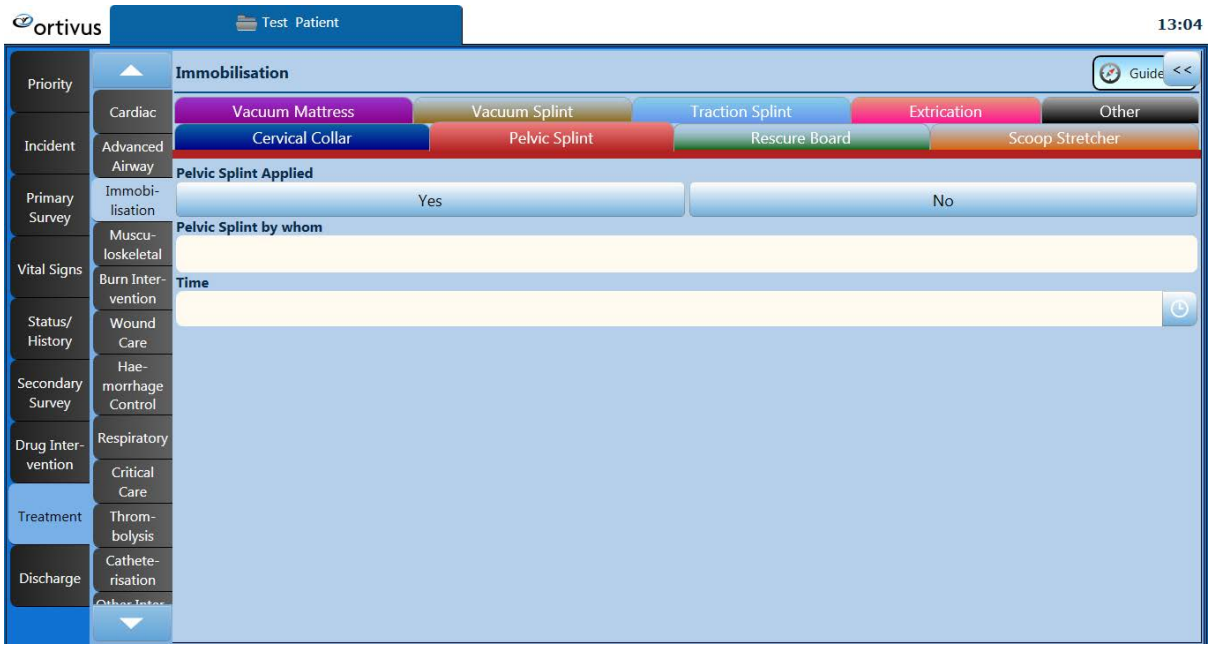


4.8.18 The **Immobilisation** screen has multiple tertiary tabs, all used to capture data relevant to specific immobilisation techniques and or equipment.

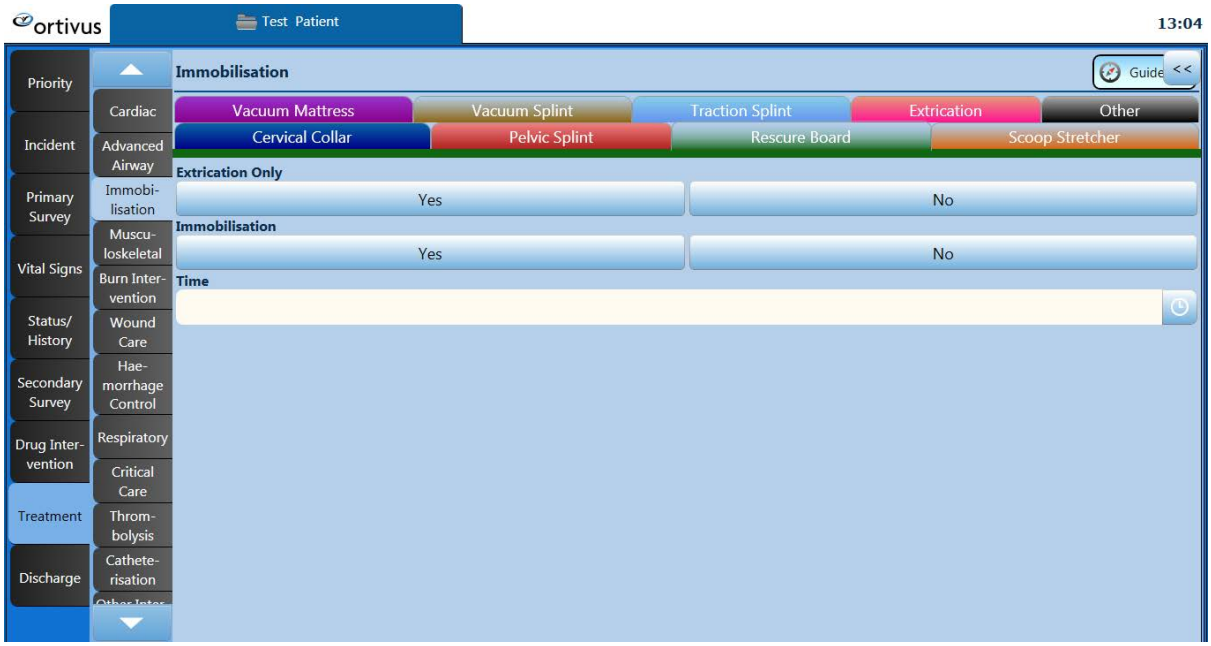
4.8.19 The **Cervical Collar** screen allows the clinician to document the Application of a collar and the relevant timings. The removal or loosening of a collar is now supported when clinically appropriate so an additional free text field is provided to capture the **Rationale** behind this decision.



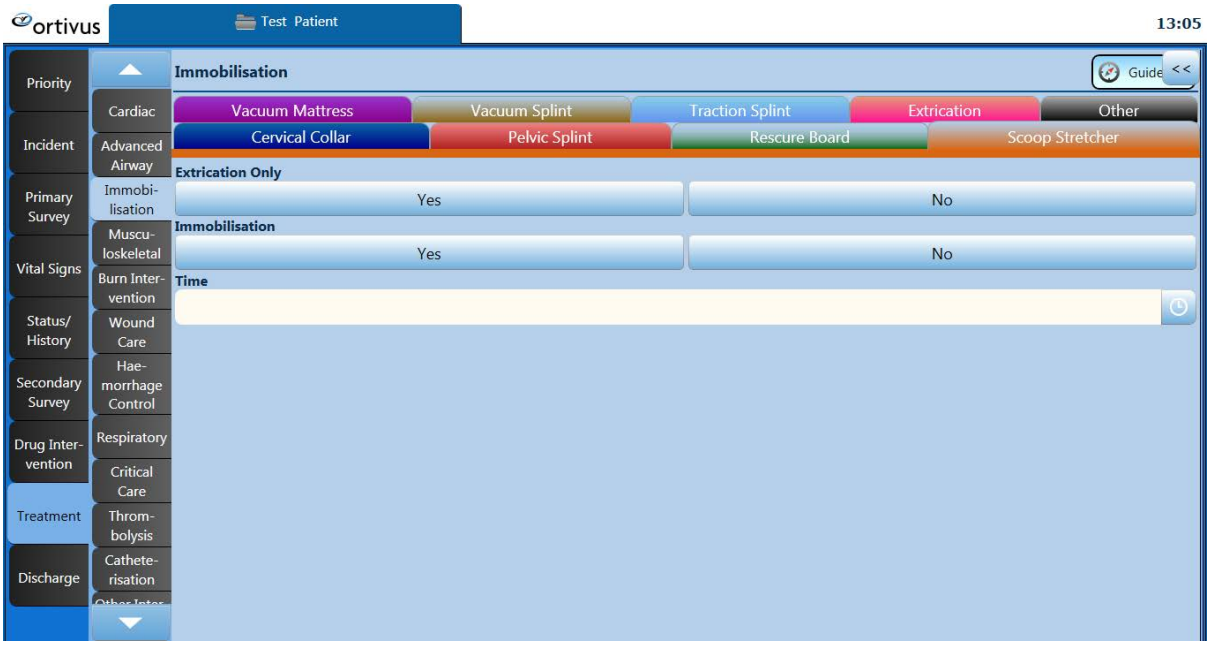
4.8.20 The **Pelvic Splint** screen provides information to show the application of the pelvic splint and associated **Time**.



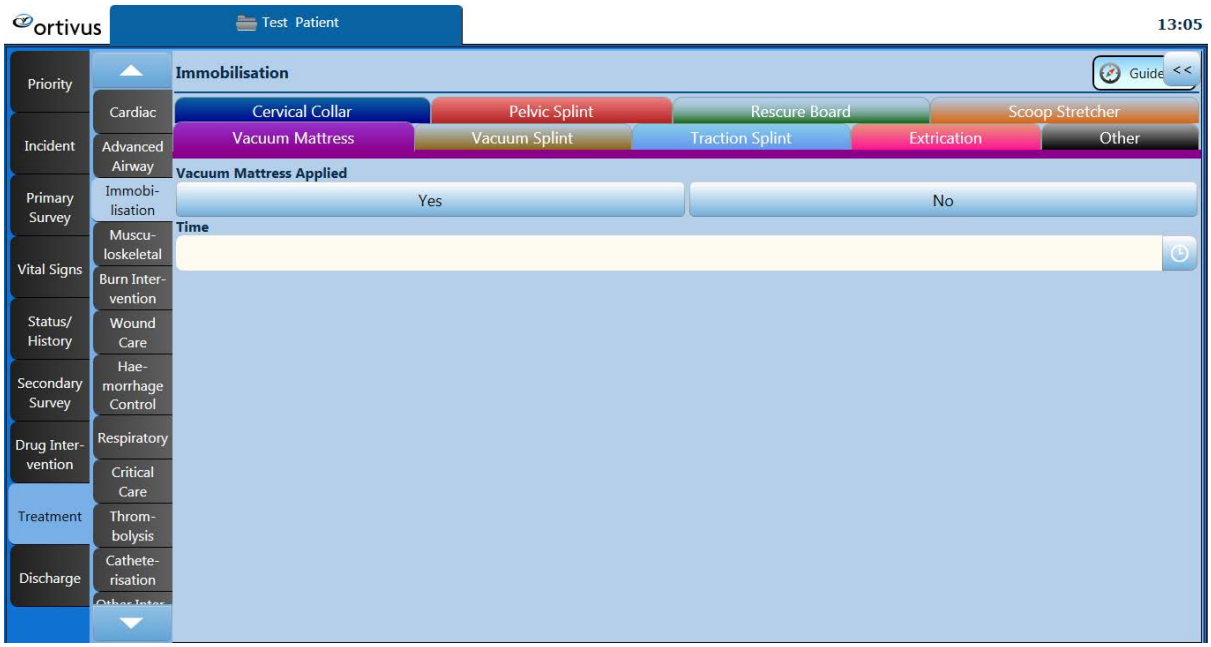
4.8.21 The **Rescue Board** can be used as a device to support extrication and be used in conjunction with a vacuum mattress and also as an immobilisation device in its own right. This screen allows the clinician to document its use in both roles.



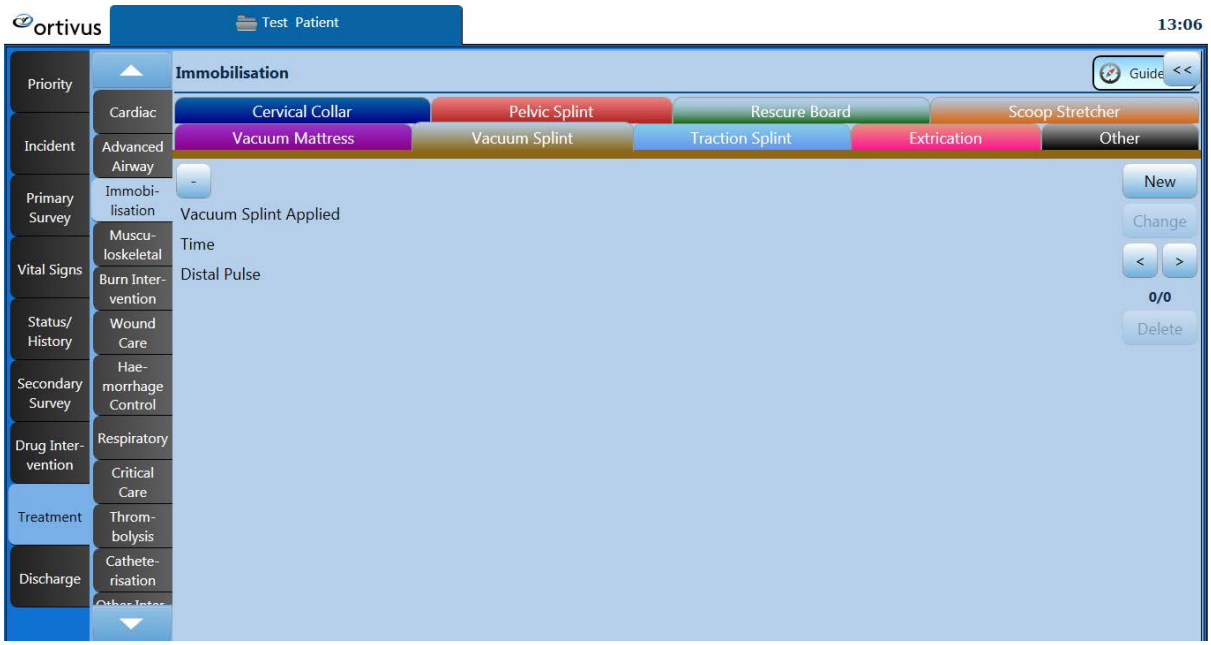
4.8.22 The **Scoop Stretcher** can be used as a device to support extrication and be used in conjunction with a vacuum mattress and also as an immobilisation device in its own right. This screen allows the clinician to document its use in both roles.



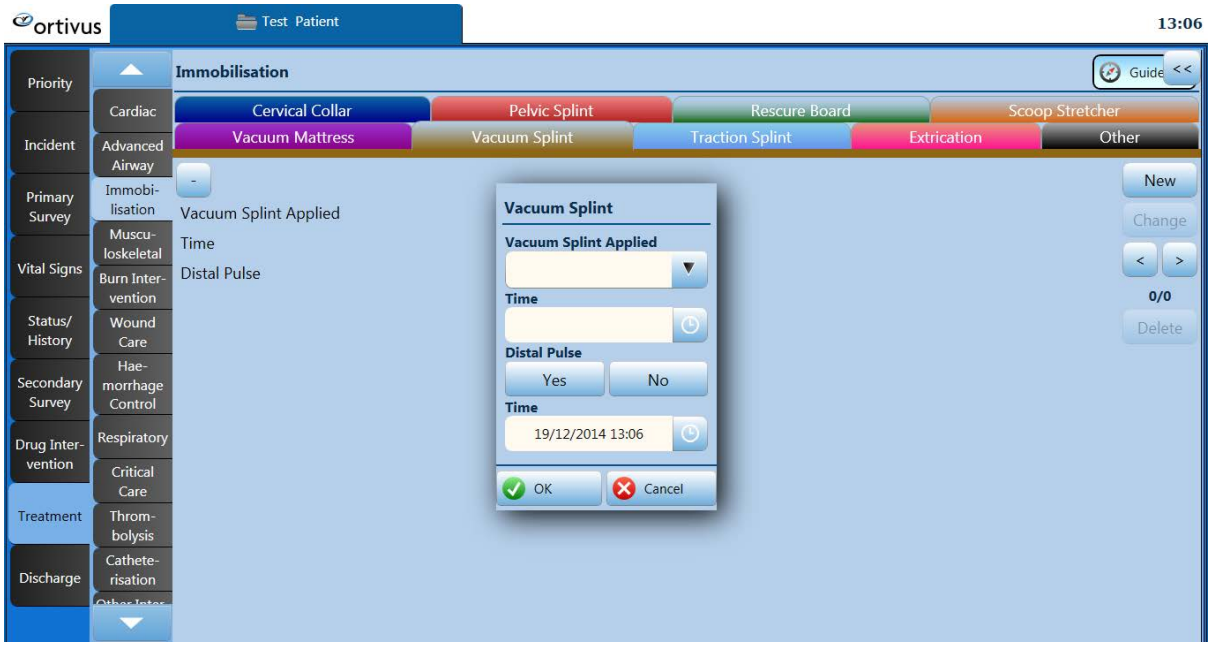
4.8.23 The **Vacuum Mattress** screen simply captures its use and the time the patient was immobilised.



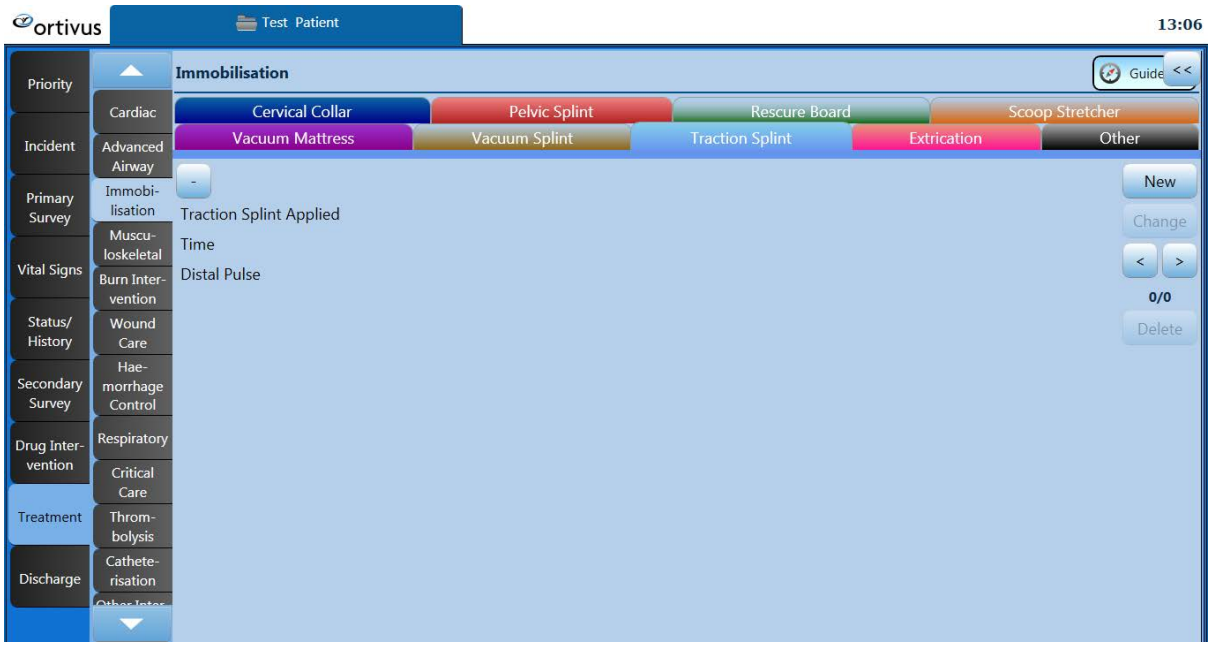
4.8.24 The **Vacuum Splint** screen allows for the capture of multiple Vacuum Splints, in order to access data fields the clinician clicks the **New** button.



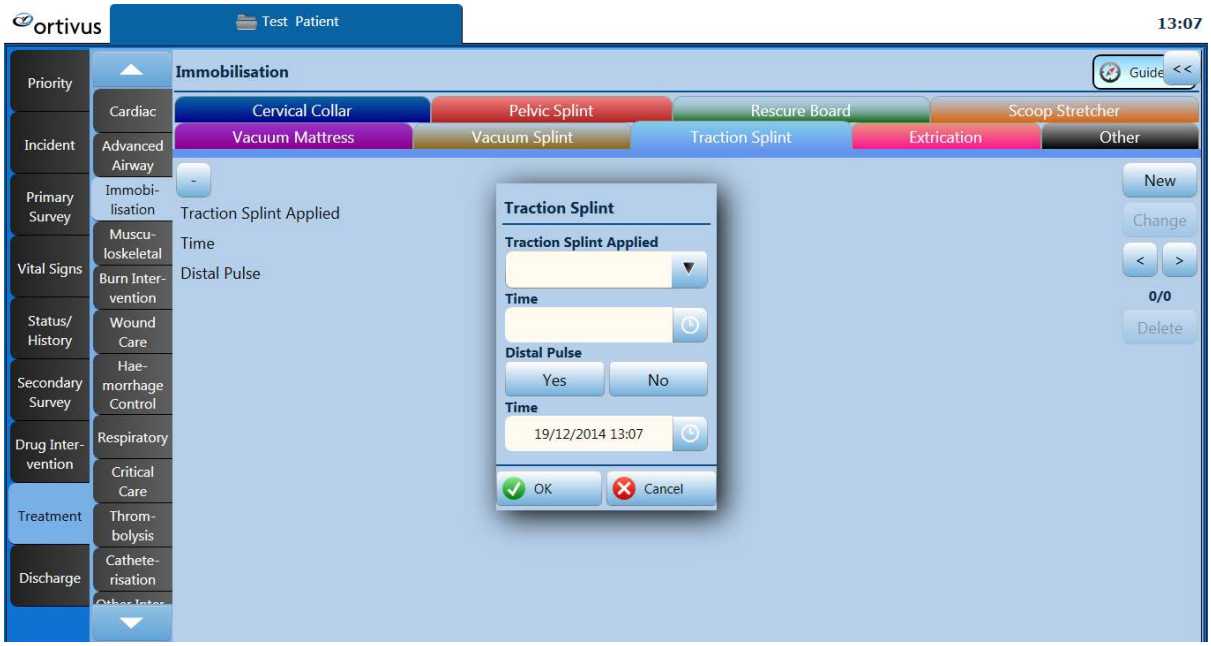
4.8.25 The **Vacuum Splint** screen will appear as below, the clinician can then provide details for the limb immobilised by clicking the down arrow. The screen also enables the clinician to confirm that post immobilisation whether a **Distal Pulse** was present.



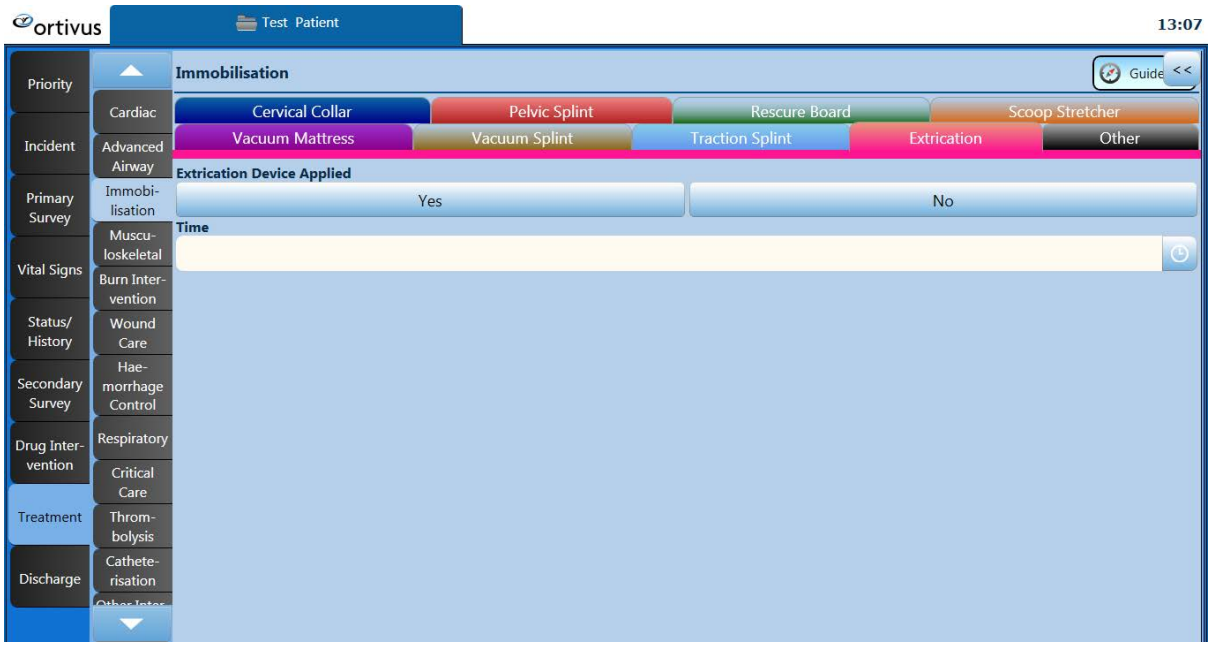
4.8.26 The **Traction Splint** screen allows for the capture of multiple Traction Splints, in order to access data fields the clinician clicks the **New** button.



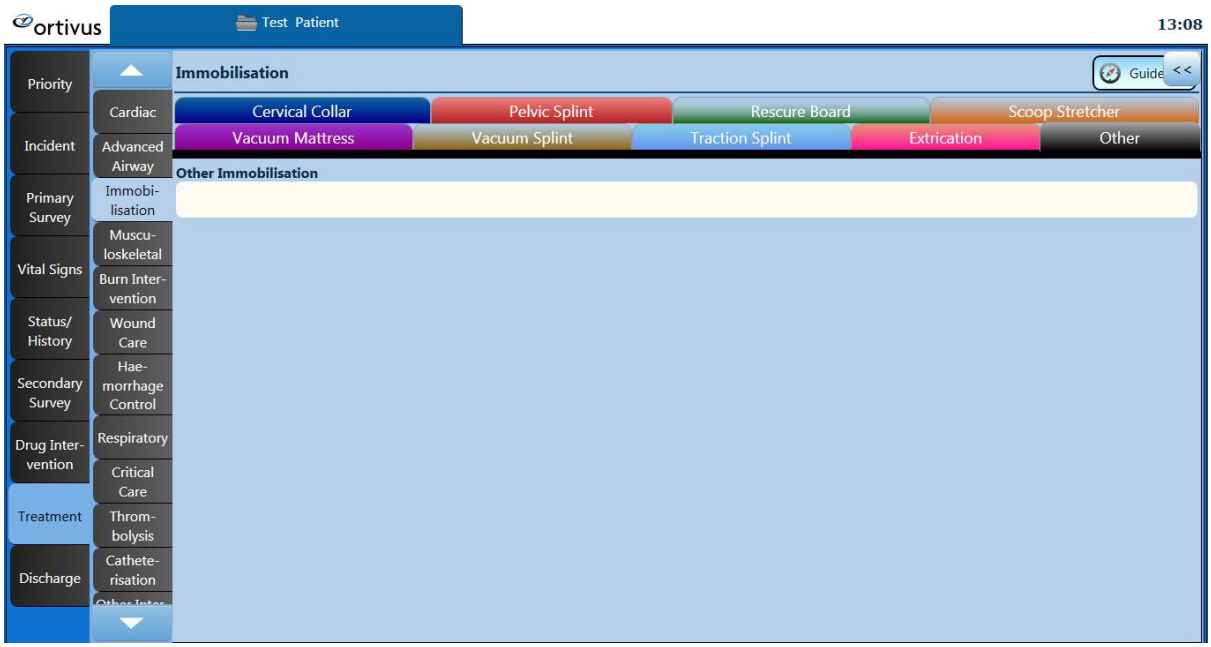
4.8.27 The **Traction Splint** screen will appear as below, the clinician can then provide details for the limb upon which traction has been applied by clicking the down arrow. The screen also enables the clinician to confirm that post traction whether a **Distal Pulse** was present.



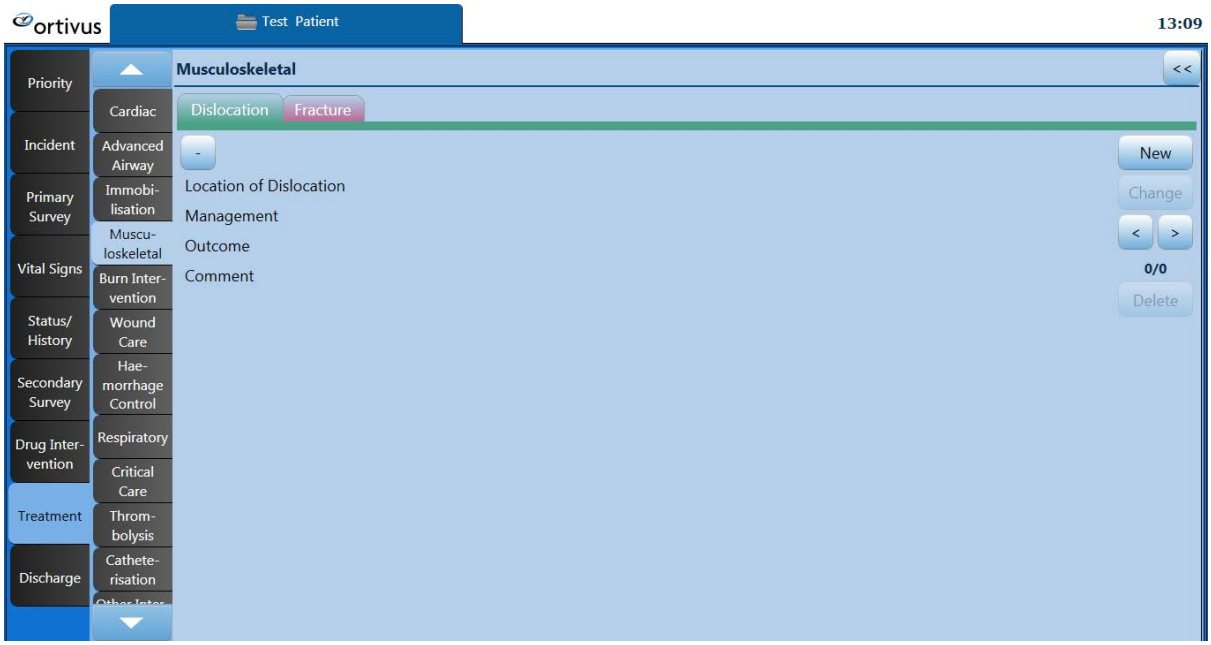
4.8.28 The **Extrication** screen simply captures the use and the time the extrication device was applied.



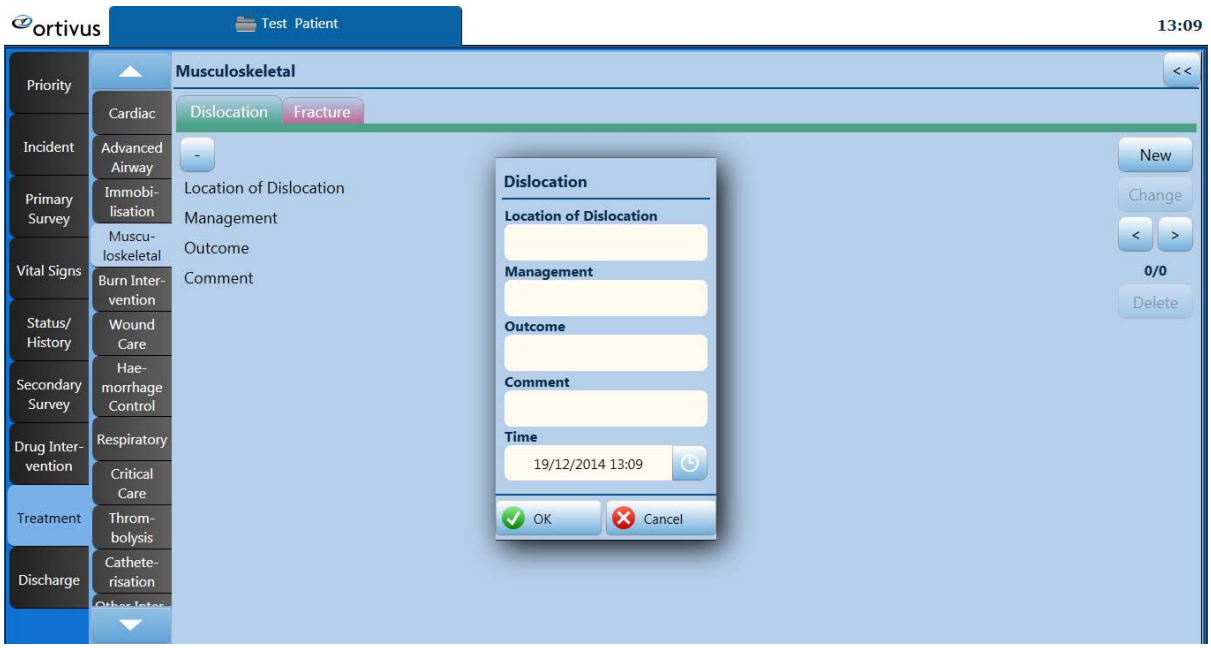
4.8.29 The **Other** screen simply allows the clinician to document in free text format, any **Other Immobilisation** used but not documented elsewhere.



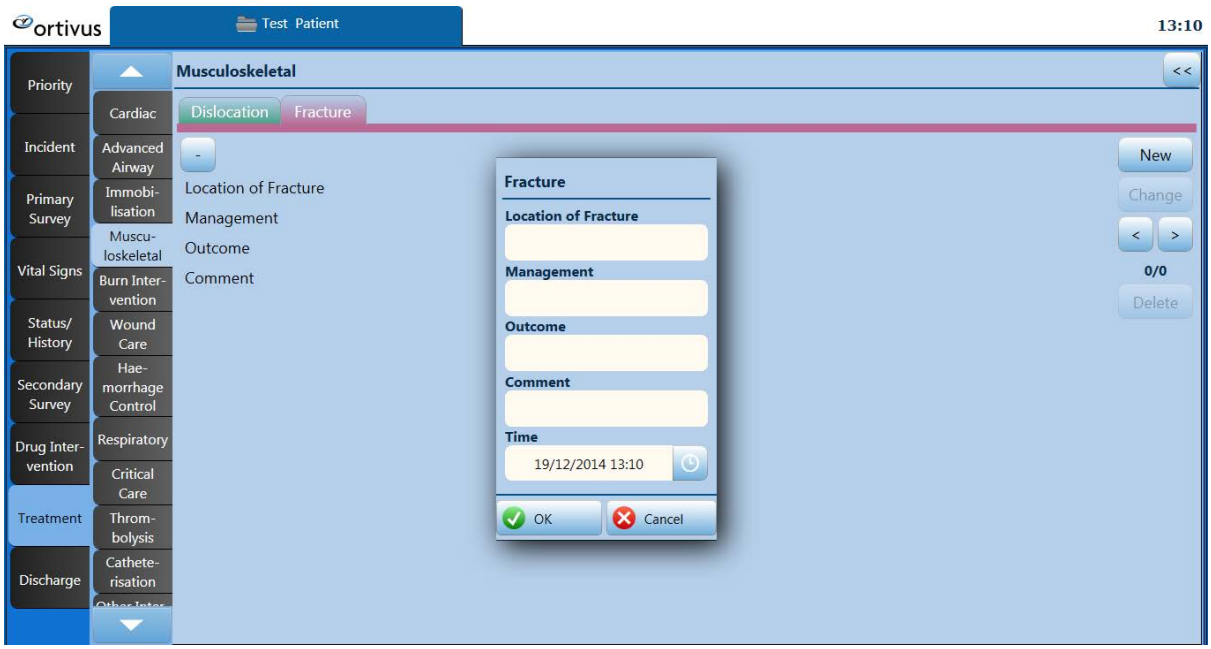
4.8.30 The **Musculoskeletal** screens provide the clinician with the ability to document the management of **Dislocations** and **Fractures** within multiple time fields. This allows the clinician to click on the **New** button to document as many dislocations and/or fractures as they have identified.



4.8.31 Once the **New** button has been clicked within the **Dislocation** screen, the box as below appears. This enables the clinician to document in free text format, the **Location of Dislocation**, the **Management** of the that dislocation, the **Outcome**, which should include details regarding distal perfusion and distal pulses and any further relevant information, such as complications and exclusions within the **Comment** field.

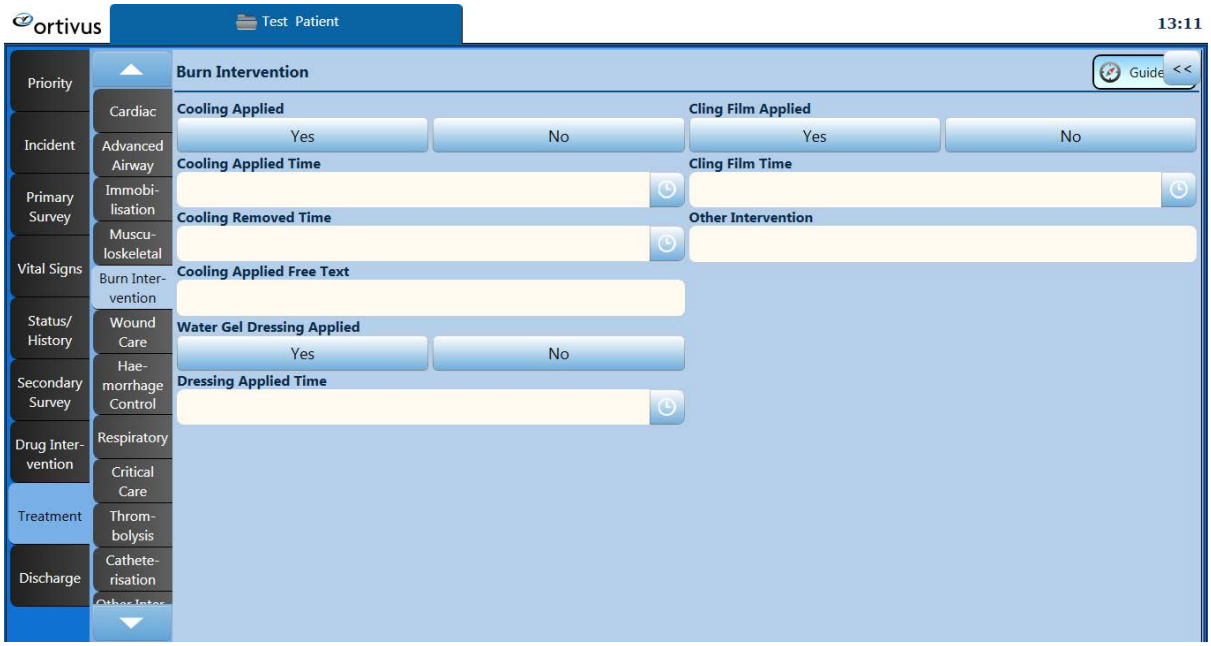


4.8.32 Once the **New** button has been clicked within the **Fracture** screen, the box as below appears. This enables the clinician to document in free text format, the **Location of Fracture**, the **Management** of the that fracture, the **Outcome**, which should include details regarding distal perfusion and distal pulses and any further relevant information, such as complications and exclusions within the **Comment** field.

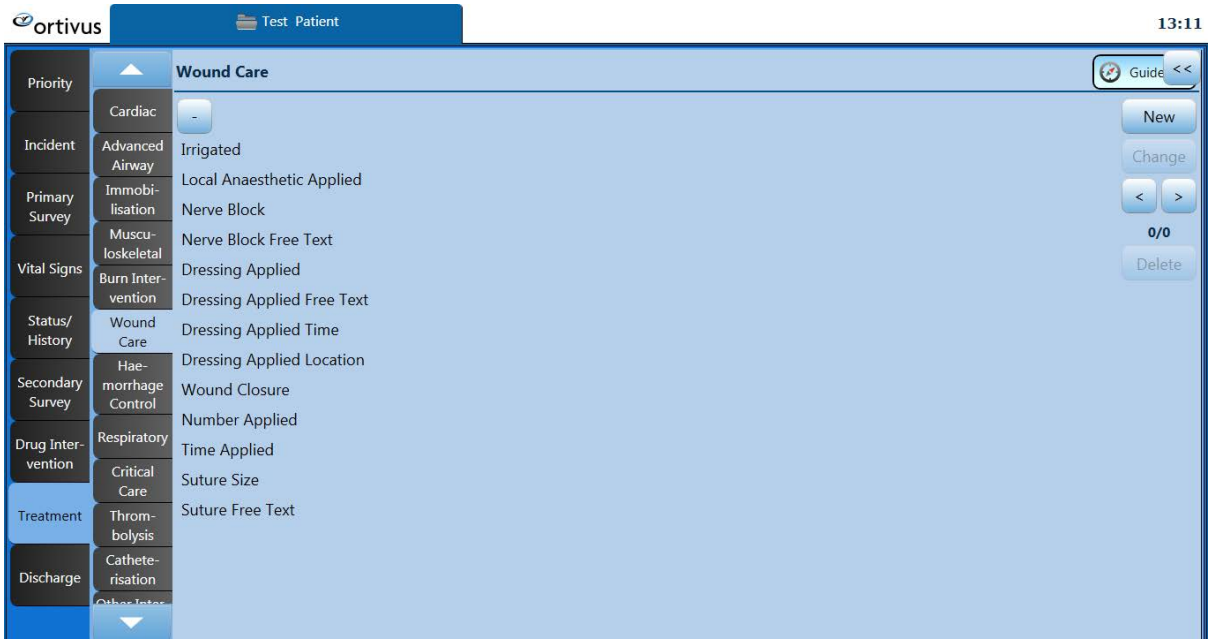


4.8.33 The **Burn Intervention** screen enables the clinician to document the application of cooling for any burn, whether this has been removed, potentially to reduce complications of hypothermia and within the **Cooling Applied Free Text** any relevant information, such as the rationale for removing the cooling.

4.8.34 The screen also captures data regarding **Water Gel** and **Cling Film** application along with a final free text field for any **Other Intervention** not captured elsewhere.



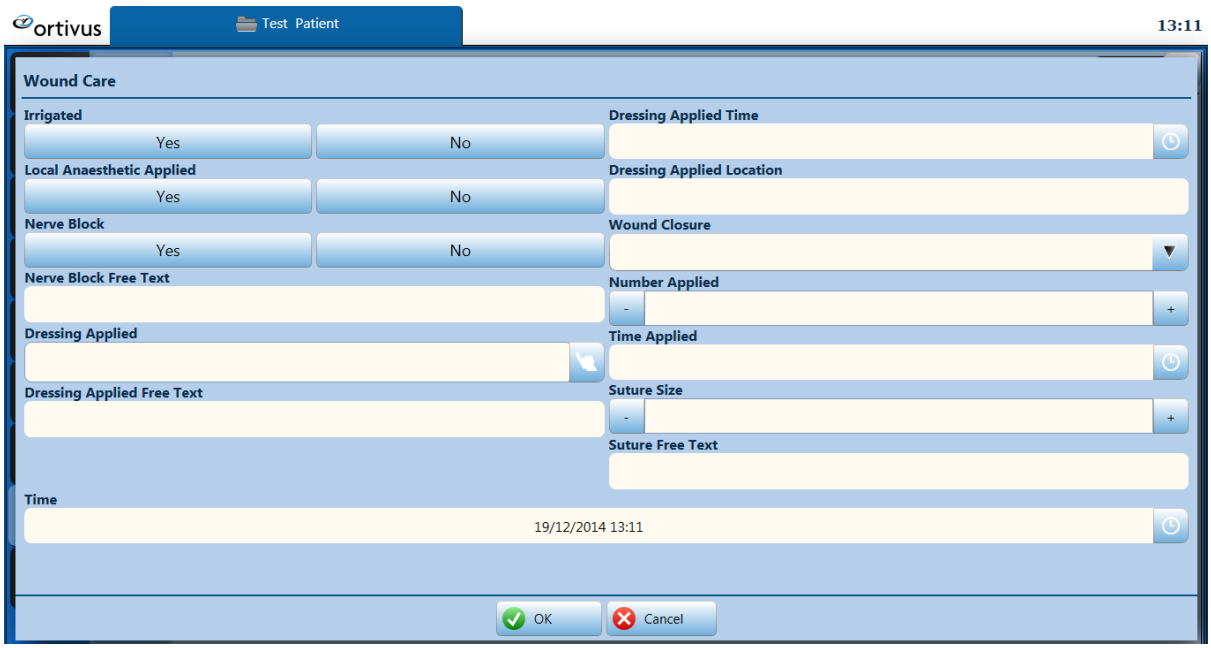
4.8.35 The **Wound Care** screen will predominantly be used by ECPs (Emergency Care Practitioners) and those deemed to be competent in the management of minor injuries. This screen allows for the capture of data for multiple injuries by clicking the **New** button for each wound managed.



4.8.36 Once the **New** button has been clicked the **Wound Care** screen appears as below. The clinician can select whether the wound has been **Irrigated** and cleaned, whether **Local Anaesthetic** has been applied, the use of **Nerve Blocks** for those trained and deemed competent in this skill can also be documented.

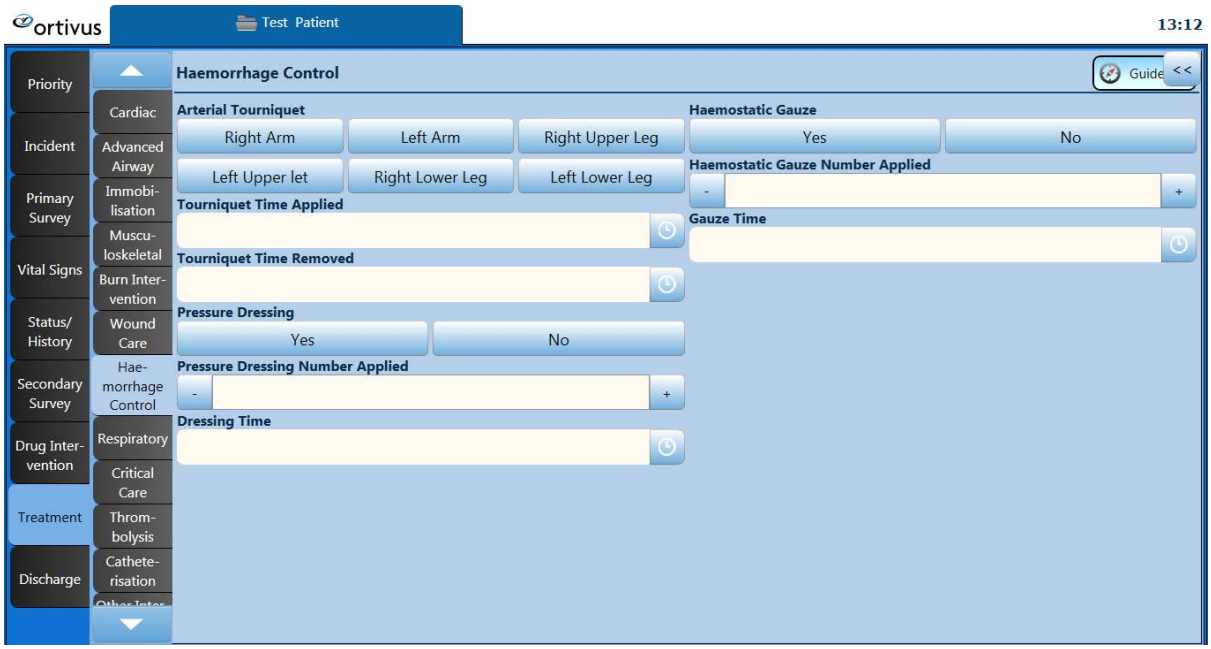
4.8.37 The clinician can select any **Dressing Applied** from a drop down list by clicking on the **white finger symbol** or use the **Dressing Applied Free Text** field to capture information related to any dressing used that is not listed.

4.8.38 In order to select the **Wound Closure** method used, the clinician clicks on the drop down menu by clicking the down arrow and then selects the **Number Applied** and the relevant **Time Applied**. This is vital should the appropriate referral for removal or after care be required.

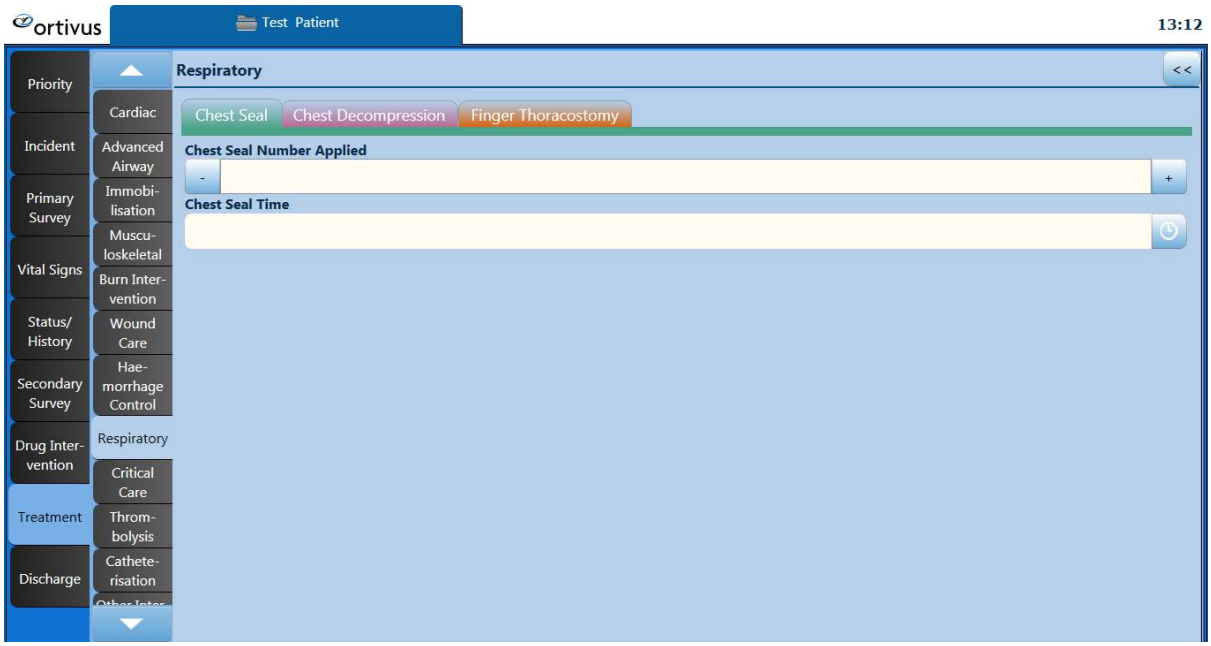


4.8.39 Should the clinician be managing any major bleed the **Haemorrhage Control** screen allows the clinician to document **Arterial Tourniquet** use, including **Time Applied** and **Time Removed**. The Tourniquet may be removed after the application of **Pressure Dressings**, should this then manage the Haemorrhage sufficiently.

4.8.40 The use **Pressure Dressings** and **Haemostatic Gauze** is also recorded along with the **Number Applied** and **Time** of application.

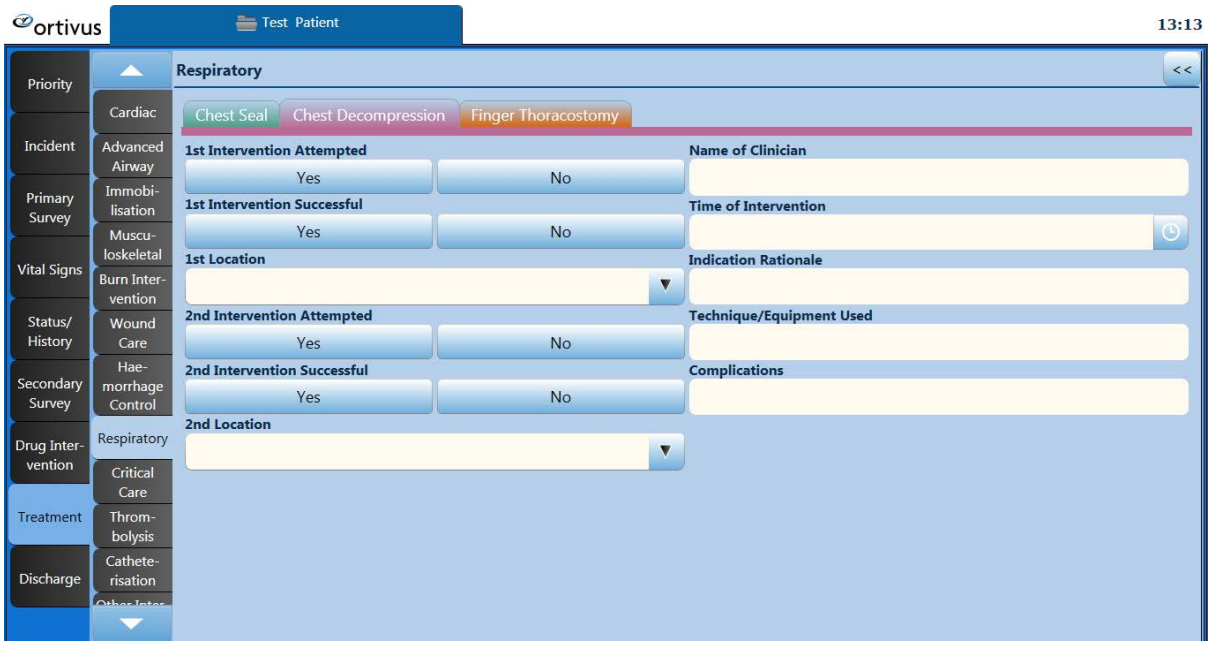


4.8.42 The **Chest Seal** screen simply allows the clinician to document the number of chest seals applied and the **Time** of application.



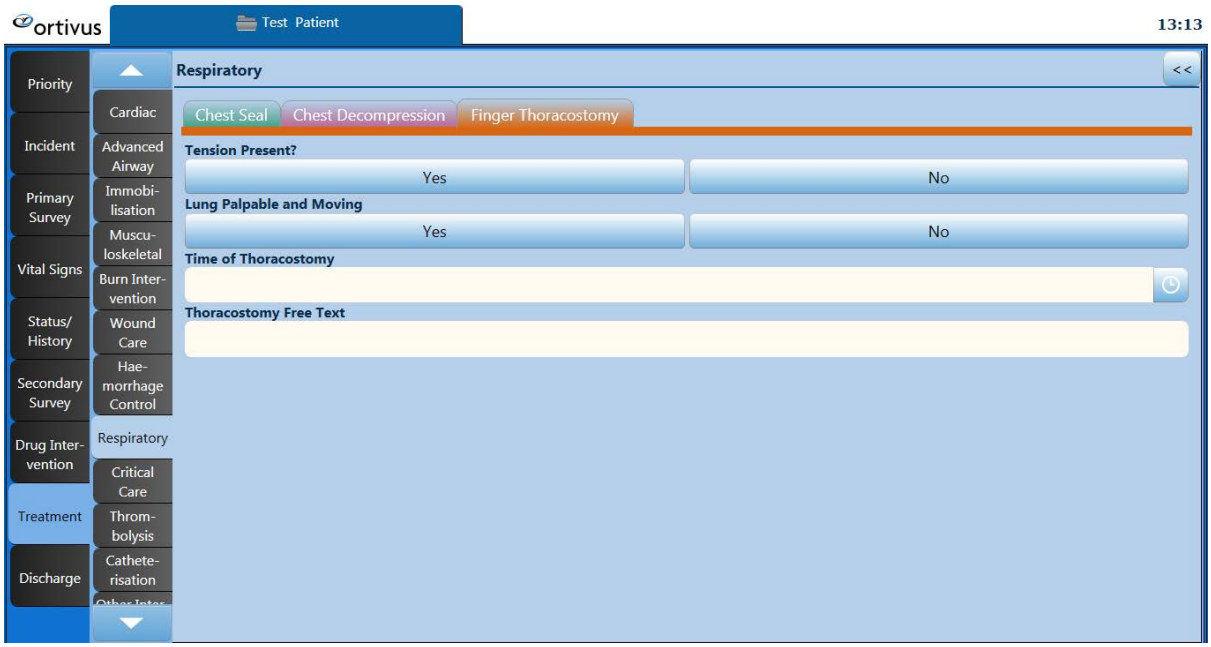
4.8.43 The **Chest Decompression** screen enables the clinician to document the attempts at Chest Decompression. This captures whether this is the primary or secondary attempt, whether the intervention has been **Successful** and the **Location** of the needle chest decompression.

4.8.44 Additional free text format fields are provided to capture the **Indication**, the **Technique/Equipment Used** and any **Complications** experienced. These fields assist in understanding the thought processes and decision making processes and are therefore very useful in any post incident review.



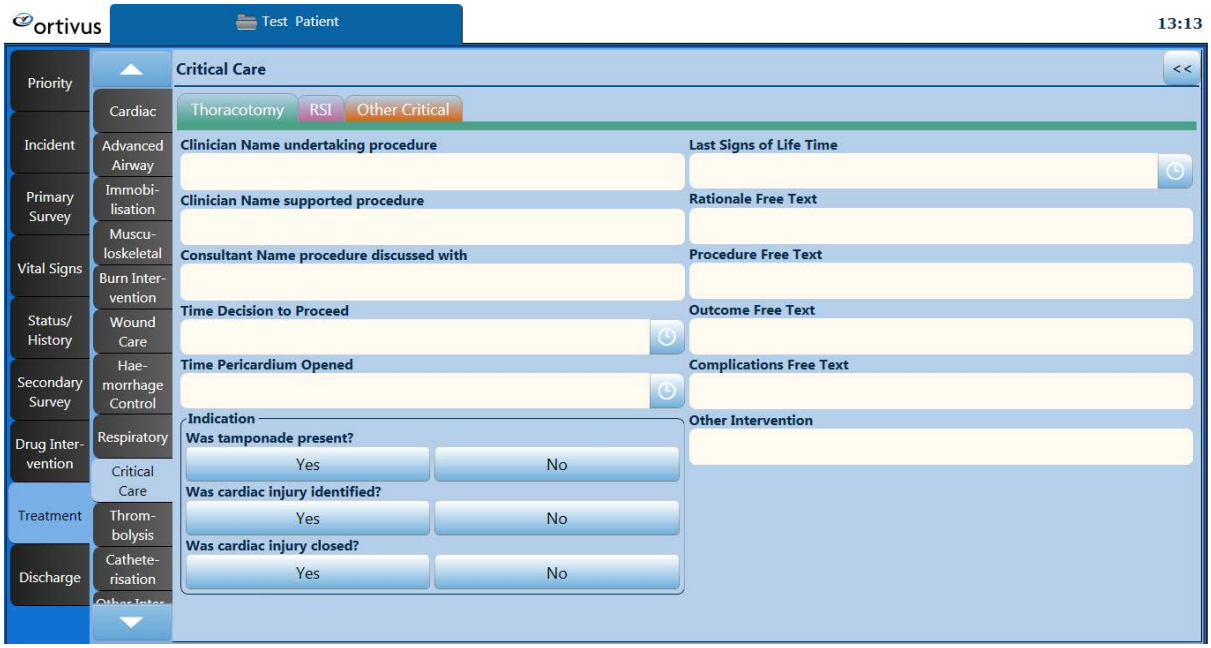
4.8.45 Should the clinician have received additional education in the provision of **Finger Thoracostomy** and have been assessed and deemed competent in this skill, the **Finger Thoracostomy** screen enables the clinician to document the use of this procedure.

4.8.46 The **Thorocostomy Free Text** field should be sued to document the **Rational**, **Indications**, **Technique** used and any **Complications** experienced. This information assist in understanding the thought processes and decision making processes and are therefore very useful in any post incident review.

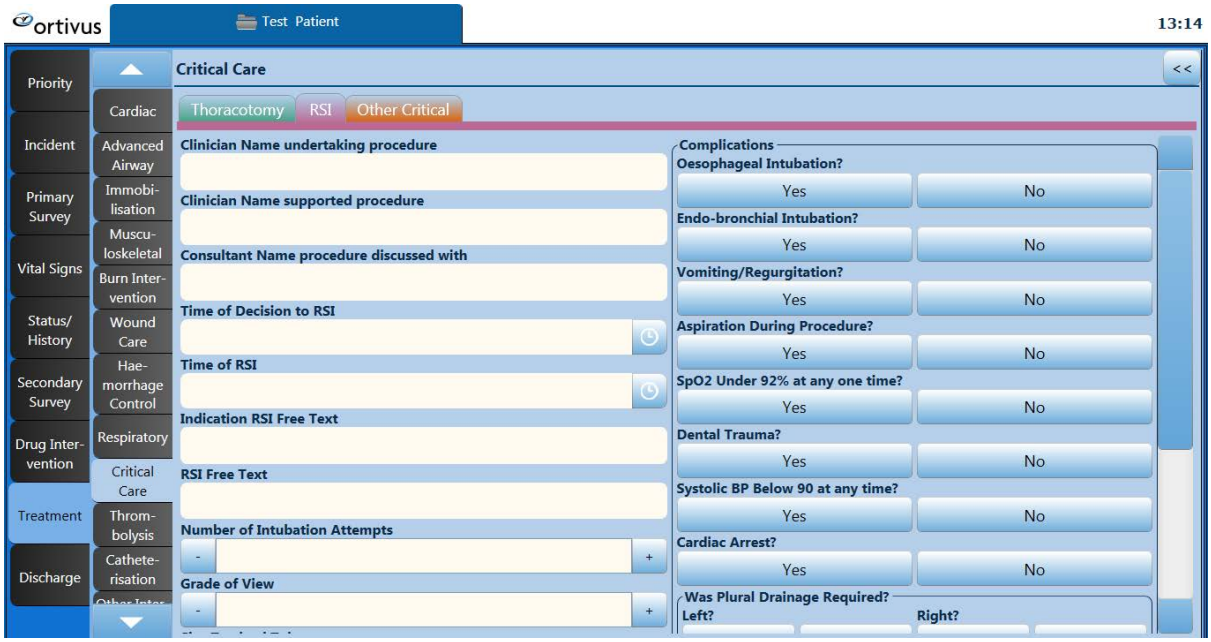


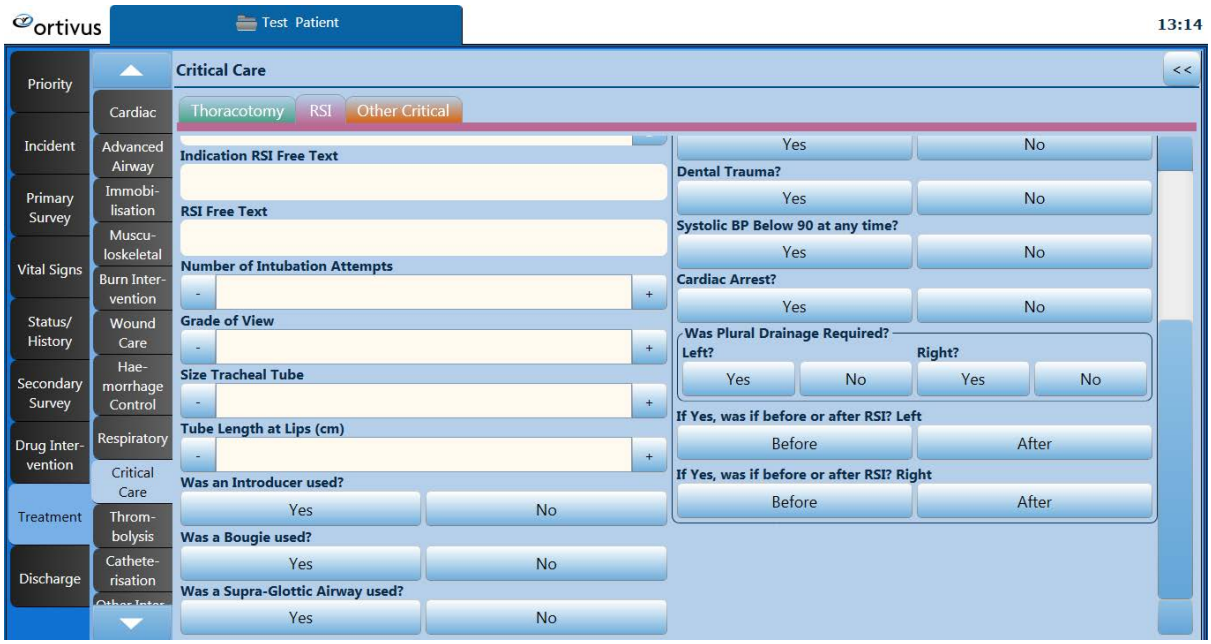
4.8.47 The **Critical Care** screen has a small number of tertiary tabs, each capturing data in relation to interventions carried out by specialist Critical Care staff. Only those who have received specific training and authority to carry out these skills should require these data fields.

4.8.48 The **Thorocotomy** screen captures this specialist intervention and requires data input mostly in free text format. This enables the identification of all those involved both directly and indirectly in the intervention and details of the procedure itself, including **Rationale**, **Procedure** used, **Outcome** and **Complications**.

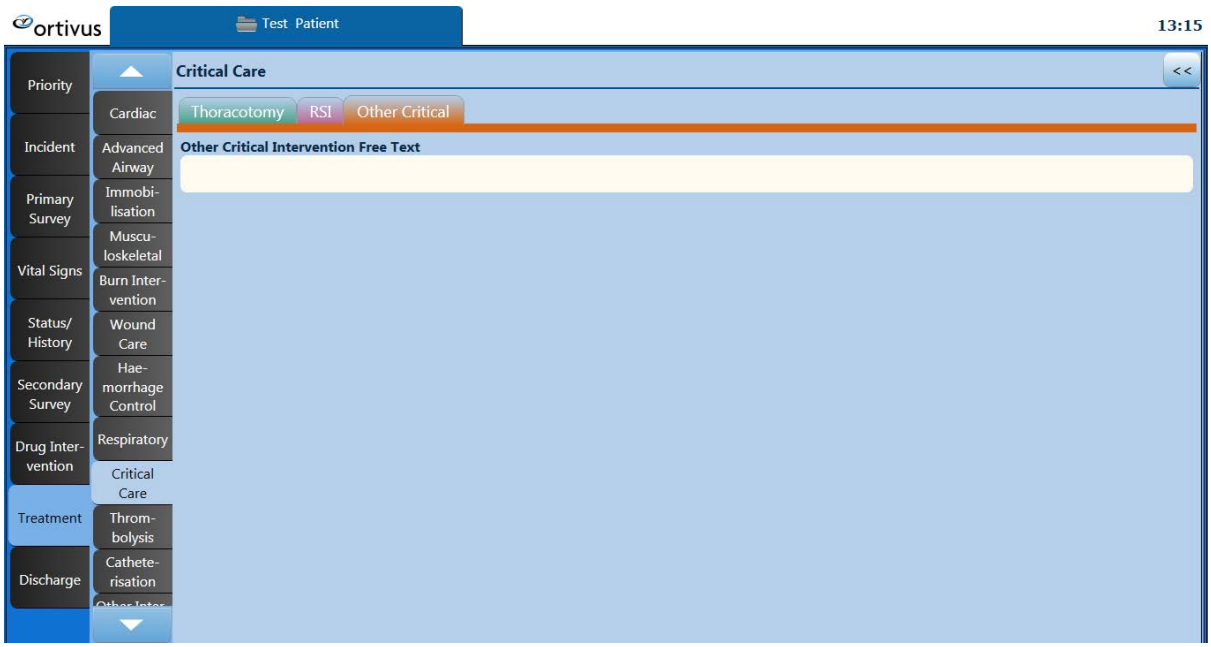


4.8.49 The **RSI** (Rapid Sequence Induction) screen as shown below captures this specialist intervention and requires data input both as binary **Yes**, **No** and free text format. This enables the identification of all those involved both directly and indirectly in the intervention and details of the procedure itself, including **Rationale**, **Procedure** used, **Outcome** and **Complications**.



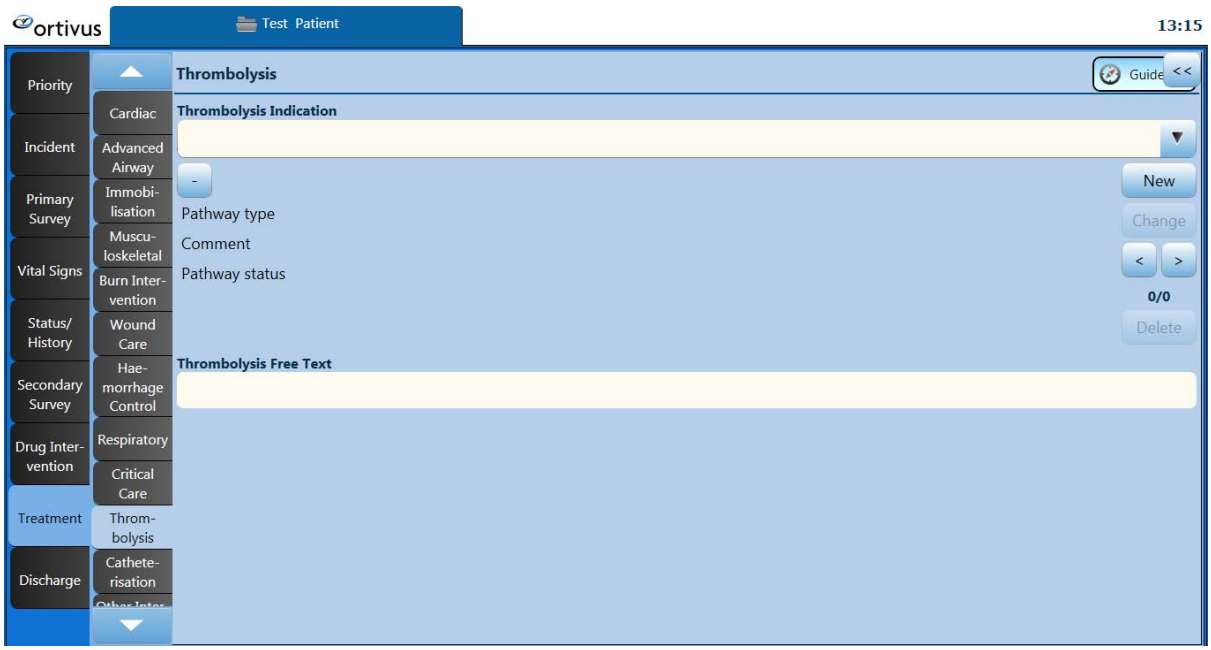


4.8.50 Given the nature of **Critical Care** and the need to provide specialist interventions outside the acute setting, the **Other Critical** screen enables the clinician to capture any other intervention that has been attempted or provided in free text format. This data field will expand as required to ensure all interventions, rational, procedures, complications and exclusions can be captured.

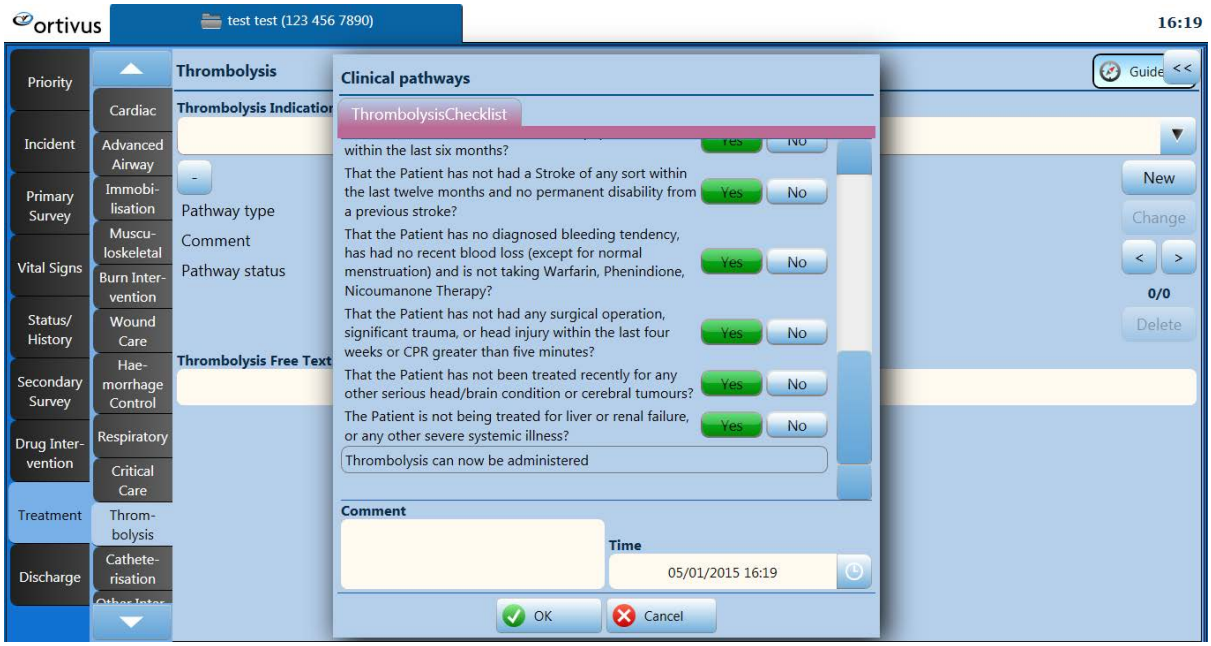


4.8.51 Whilst not an intervention used frequently since the use of direct to catheter laboratory pathways have been introduced, the **Thrombolysis** screen captures any use of Thrombolysis in the pre-hospital field.

4.8.52 The clinician can select the Indication for **Thrombolysis** using the **down arrow** and then click on **New** to access the Thrombolysis checklist.

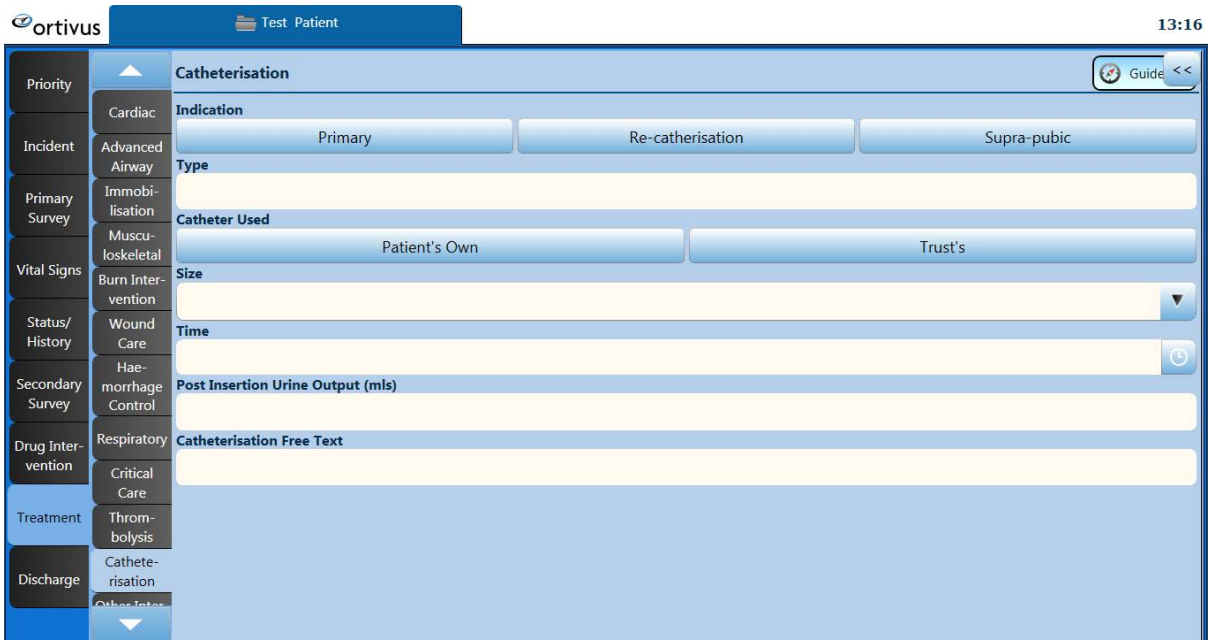


4.8.53 The clinician can select the Indication for **Thrombolysis** using the **down arrow** and then click on **New** to access the Thrombolysis checklist. Once complete the checklist will indicate, as below, whether the patient is suitable for Thrombolysis.

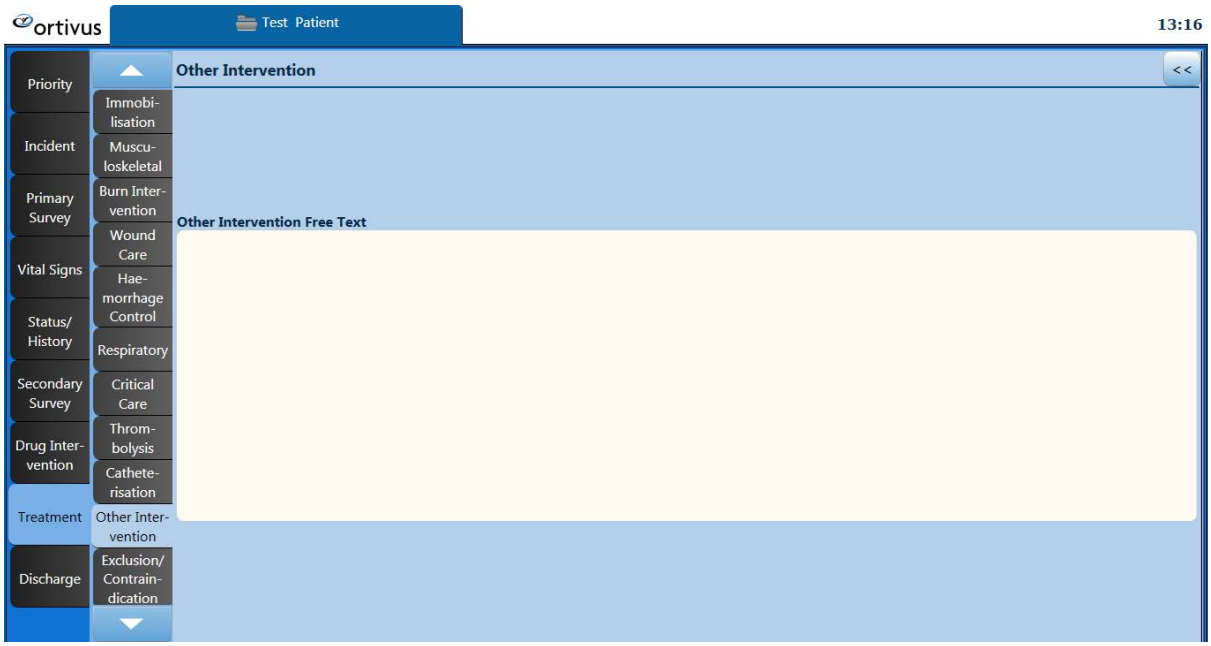


4.8.54 The **Catheterisation** screen enables those clinicians trained and deemed competent in urinary catheterisation to document the use of this intervention. The clinician can identify if this is a **Primary** intervention possibly to relieve acute retention, **Re-catheterisation** to remove and replace a blocked catheter or the removal and replacement of a **Supra-pubic** catheter.

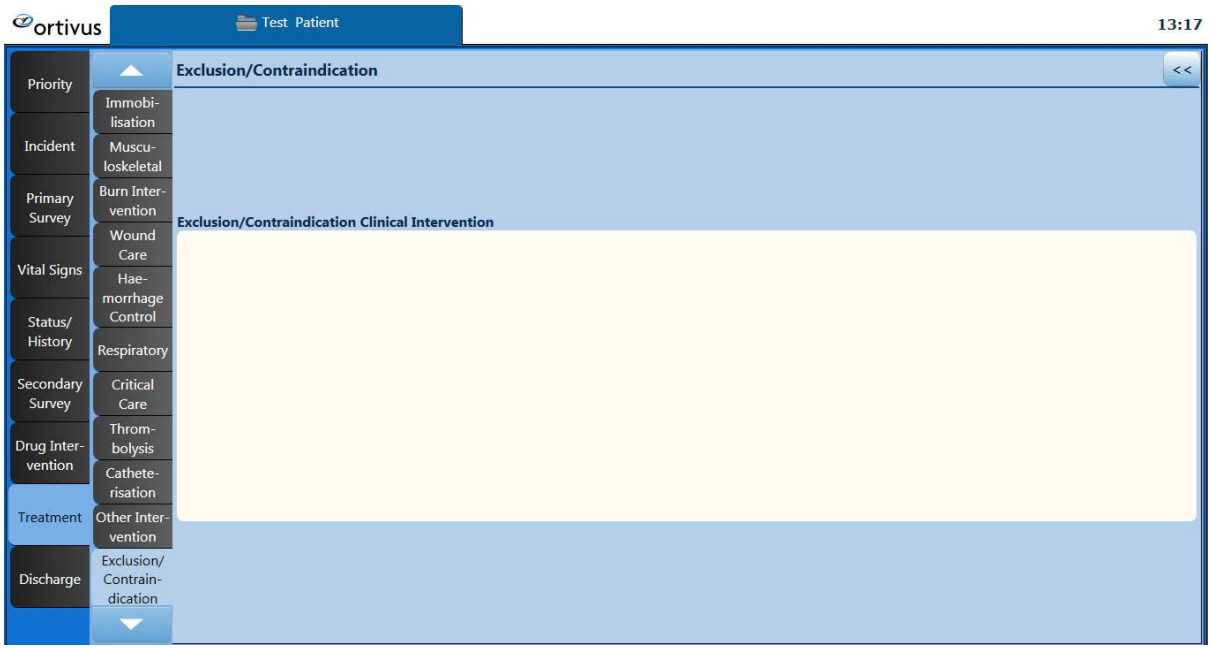
4.8.55 It is important that the clinician documents the Post Insertion Urine Output and additionally should ensure any complications and the details of appropriate follow up and referral are captured within the **Catheterisation Free Text** field.



4.8.56 The **Other Intervention** field allows the clinician to document any other intervention, not recorded elsewhere, that has been applied in free text format.



4.8.57 The **Exclusion/Contra-indication** field allows the clinician to document any other deviation from clinical guidelines and or any contraindication to treatment, not recorded elsewhere, that has been provided in free text format.



4.9 Primary Tab – Discharge

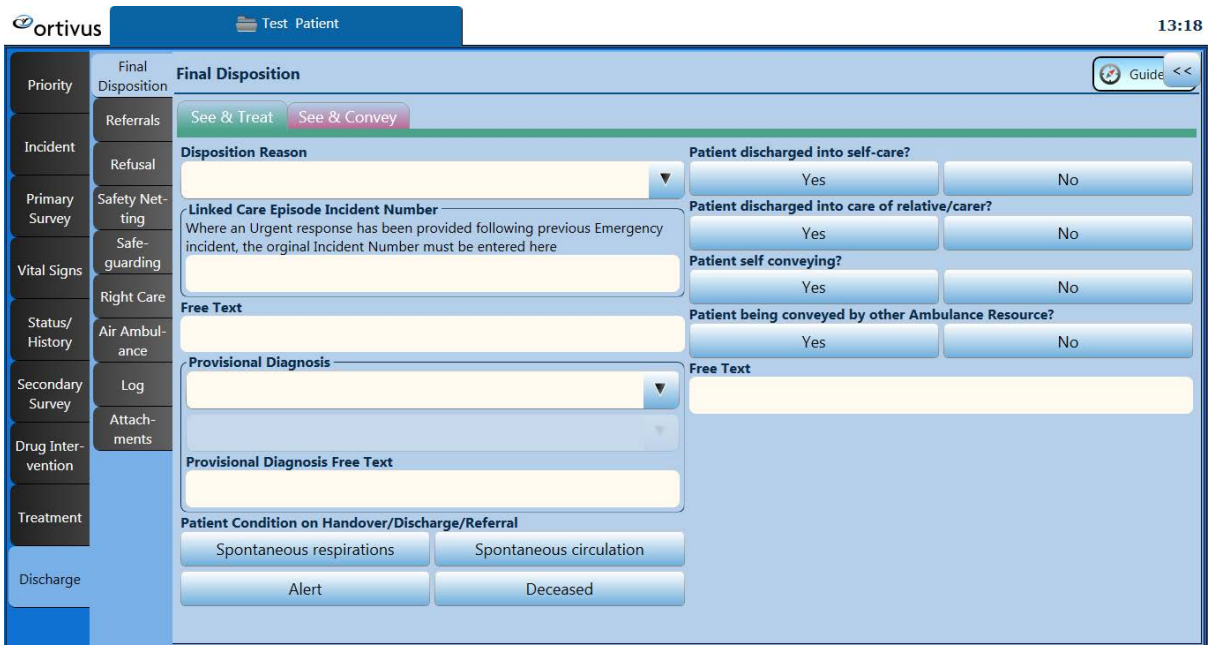
4.9.1 Final Disposition

4.9.2 The **Final Disposition** screen has two tertiary tabs to capture details of any patients who are managed without conveyance (**See & Treat**) and any patients who are conveyed (**See & Convey**)

4.9.3 Within See & Treat the clinician can document the Reason for Disposition which may be that the crew have been stood down or the patient has been conveyed by another resource. The clinician can also document the **Linked Care Episode Incident Number**, this is for incidents attended earlier as an emergency response, which is being managed as an **Urgent incident**.

4.9.4 Details of the **Provisional Diagnosis** can be provided using the drop down arrow as below and also with the **Provisional Diagnosis Free Text** field which will expand as required to capture any information relevant to the Provisional Diagnosis not entered elsewhere within the ePCR.

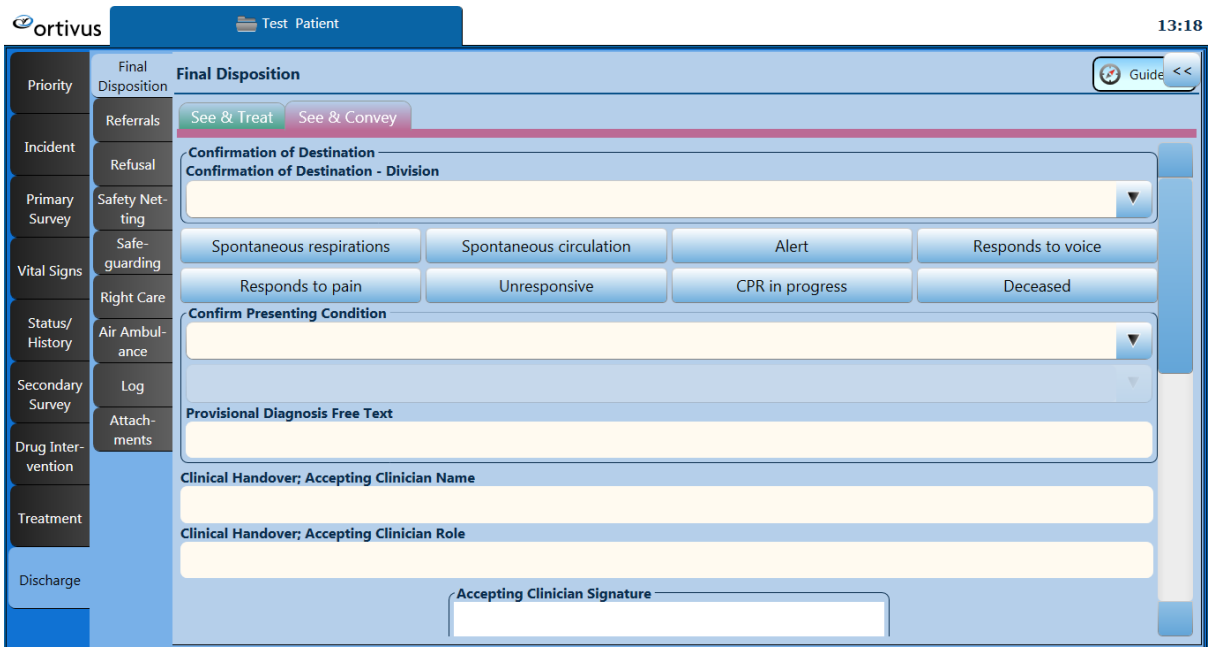
4.9.5 Details of the patients discharge can be entered using the **Yes**, **No** buttons provided or the final **Free Text** field provided.



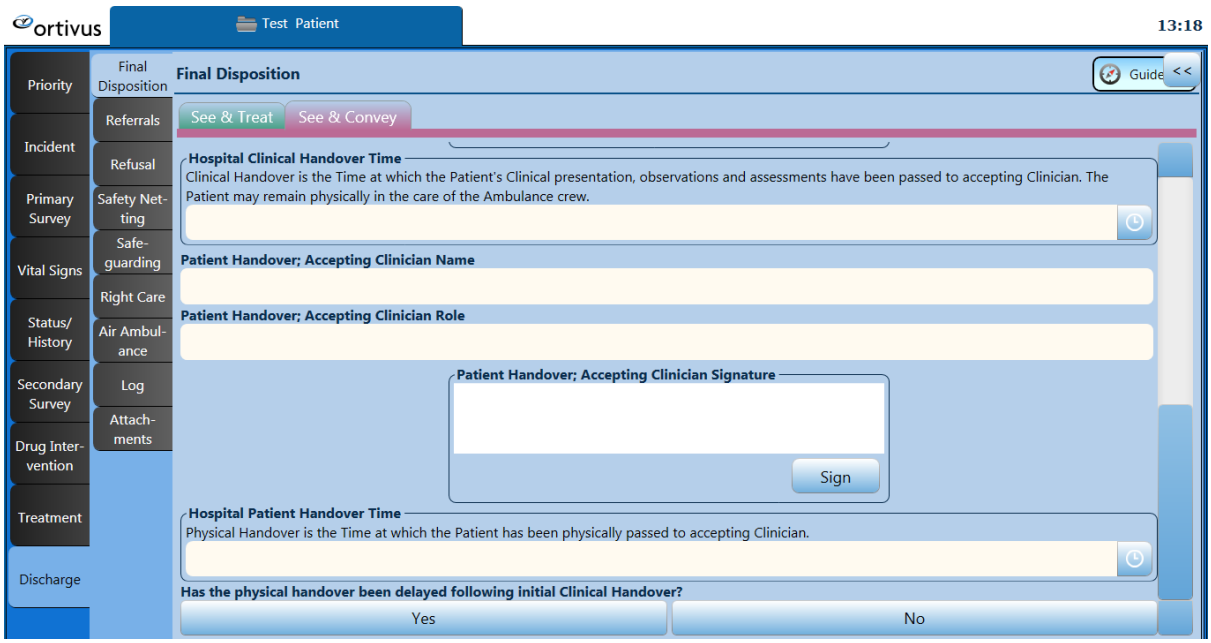
4.9.6 The See & Convey screen enables the clinician o document the patients condition on hand over to the receiving clinician. This includes status via the large buttons which can be multi selected to include patients for example who have **Spontaneous Respirations**, **Spontaneous Circulation** and are **Alert**.

4.9.7 Details of the **Presenting Condition** can be provided using the drop down arrow as below and also with the **Provisional Diagnosis Free Text** field which will expand as required to capture any information relevant to the Provisional Diagnosis not entered elsewhere within the ePCR.

4.9.8 The details of the clinician who is accepting the **Clinical Handover** can then be entered along with a signature if required. The signature field can be accessed by clicking on **Change** button and then the clinician uses the stylus provided to sign the appropriate box on the screen.

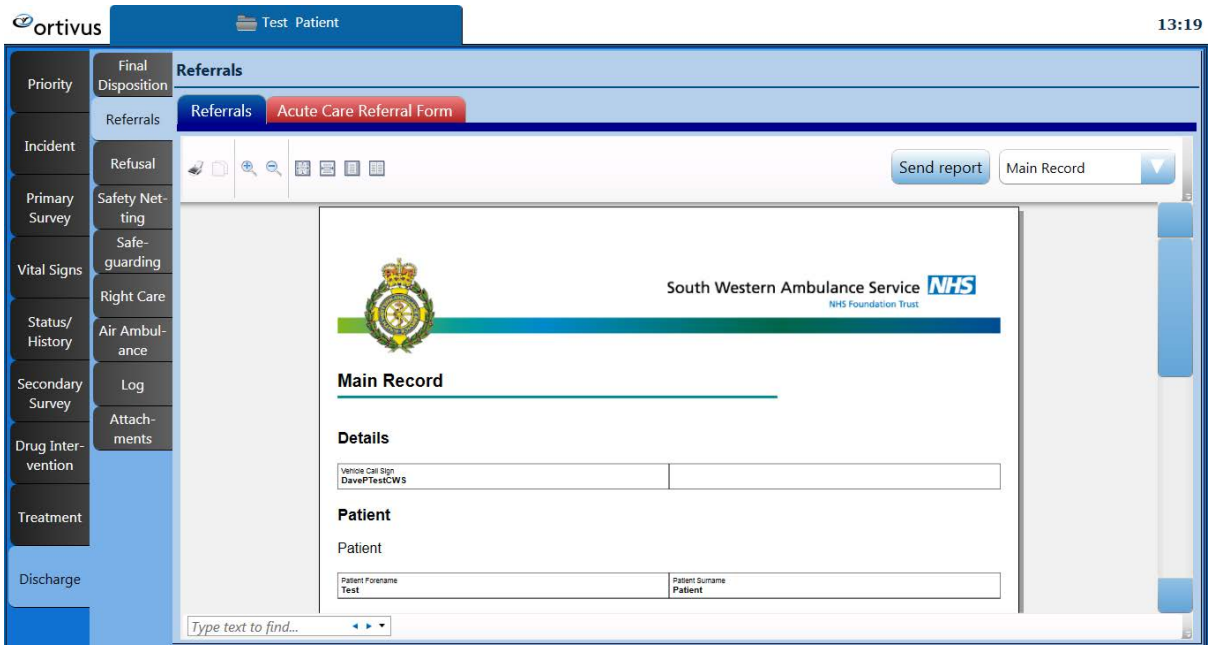


4.9.9 Should there be a delay between the **Clinical Handover**, the point at which the clinical details are provided to the accepting clinician and the **Physical Handover** or **Patient Handover**, i.e. the point at which the patient is physically transferred from the ambulance crew to the receiving hospital allowing the ambulance clinician to return to operational duties, fields are duplicated for to capture this delay.

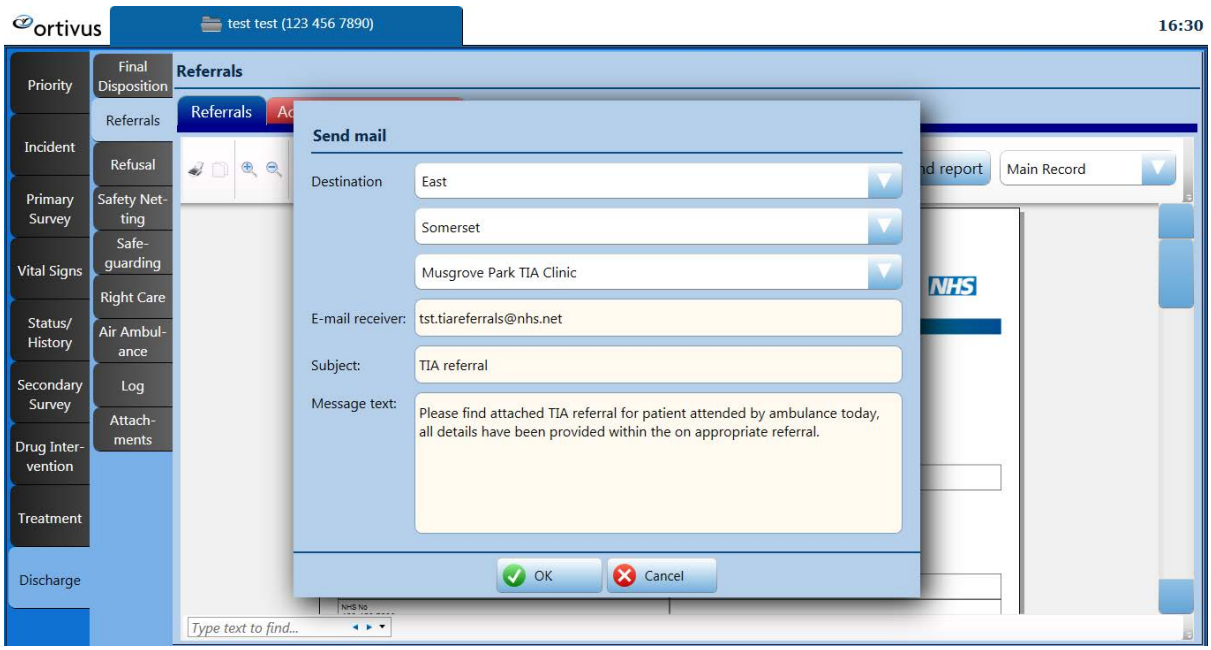


4.9.10 The **Referrals** screen enables the clinician to utilise pre-populated referral forms for onward management of the patient. A series of options are provided once the **large white down arrow** is clicked. In the example below the **Main Record** has been selected. This record will then pre-populate with information entered into the ePCR. The output Record/Referral will only collect data from the ePCR for data fields where data has been entered, so any referral form is reliant on the clinician's completion of the ePCR. For example if the **Falls** section within **Secondary Survey** has not been completed, the **Falls Referral** if selected would be missing a large proportion of its data and not be fit for purpose. **The main record can also be used by the clinician to review all data entered thus far so as to ensure that the patients assessment and management is appropriately documented prior to closing and signing the record.**

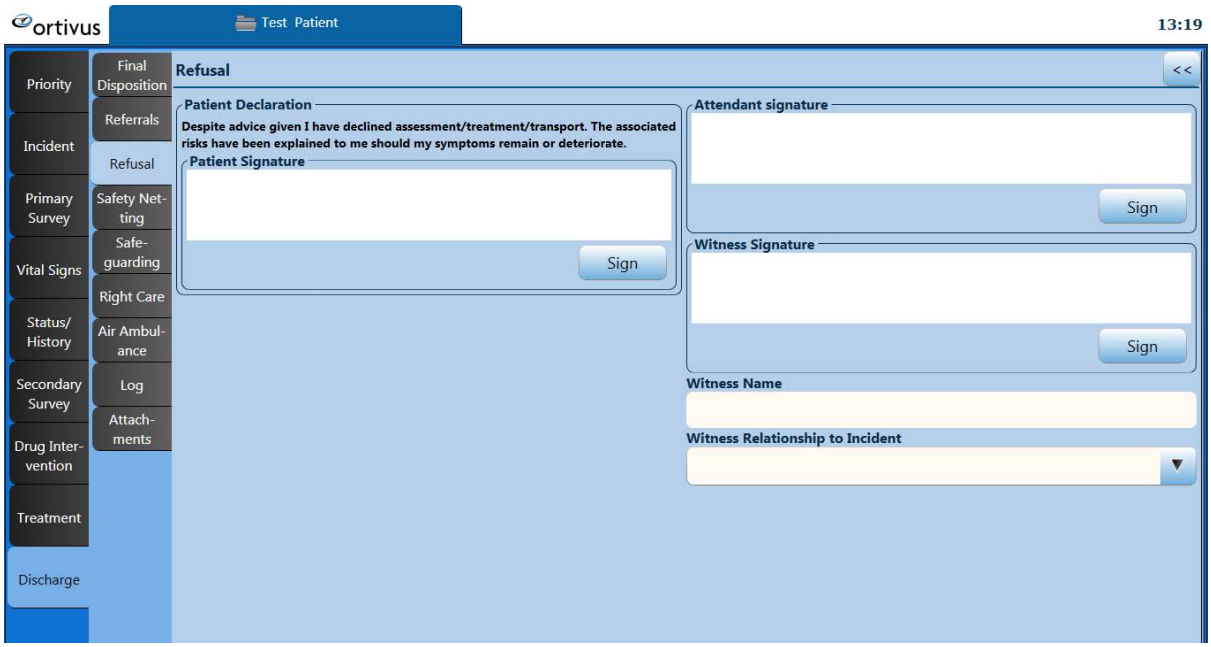
4.9.11 Once the record is finalised and ready for appropriate referral, the clinician can select **Send Report** to access a closed list of appropriate email addresses.



4.9.12 Once Send has been selected the appropriate email address can be sourced using the white drop down arrows, as below. This will enable the onward referral of patients to services who have provided a secure NHS email account. Any additional information which is required in order to provide the recipient with guidance as to why the email referral is being sent can be entered into the **message text** box as below.



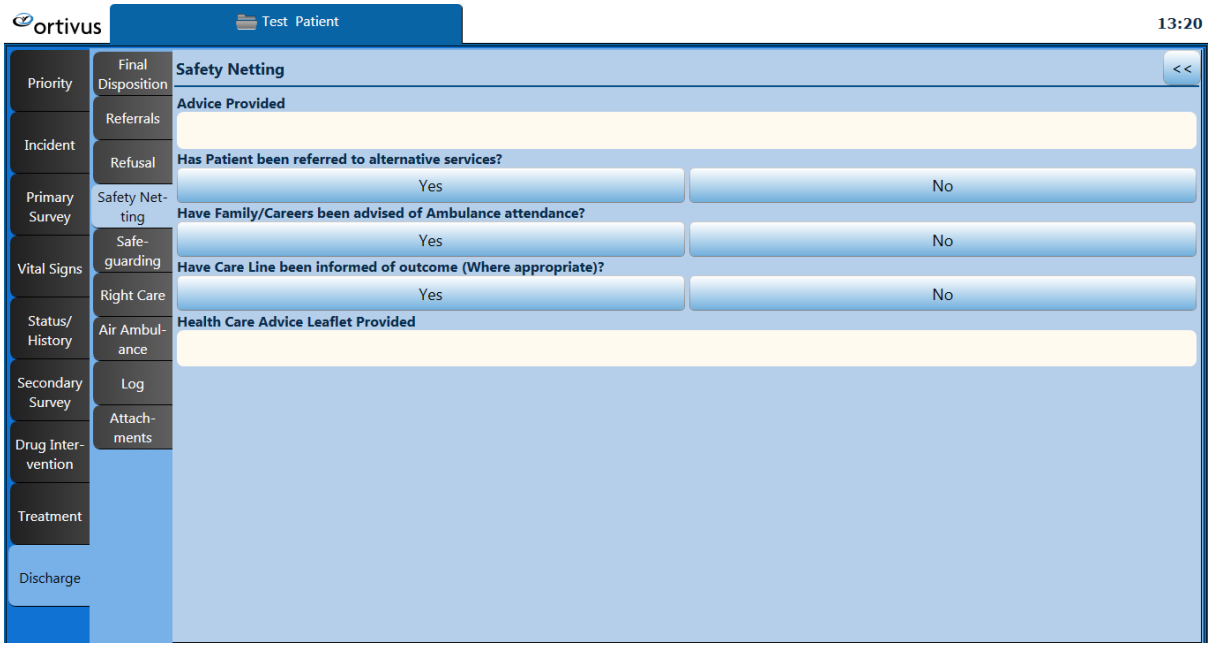
4.9.13 The **Refusal** screen enables the clinician to capture details of any patient who declines treatment and or transfer against the clinicians advice. The **Patients Signature** along with **Attendant Signature** and any appropriate **Witness Signature** can all be captured by clicking **Sign** and then by using the stylus to sign directly onto the screen. It is important that the patient is given the opportunity to read the **Patient Declaration**, or that this is communicated to them by other means as necessary.



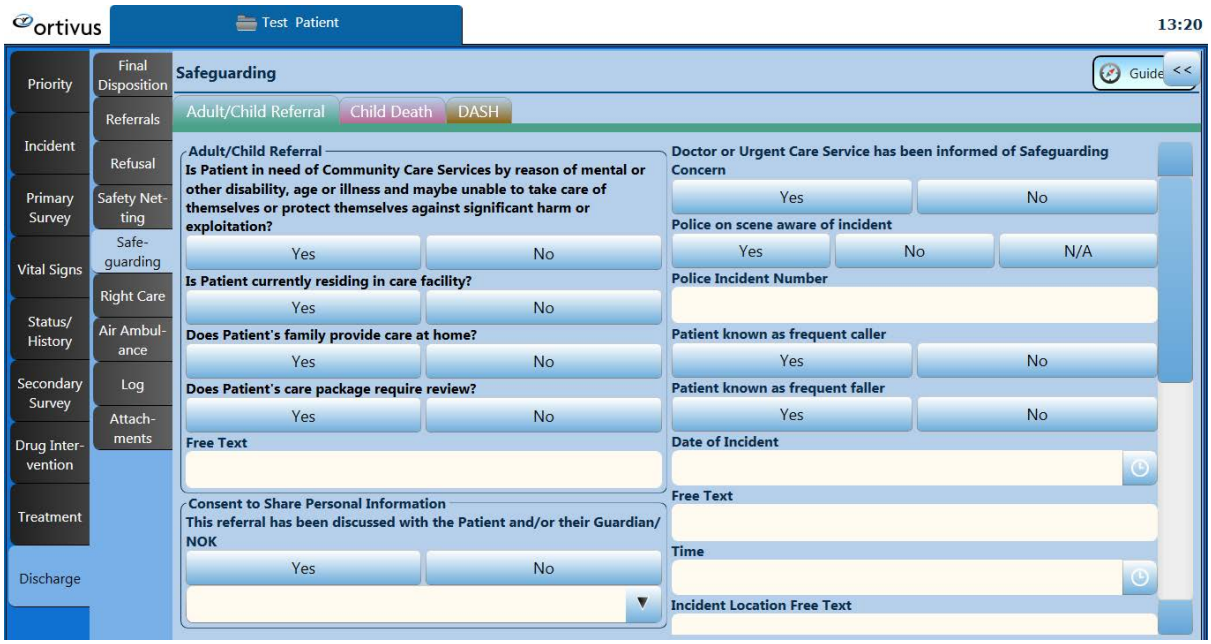
4.9.14 The increasing management of patients outside the Emergency Department requires the clinician to appropriately manage any deterioration and to provide appropriate **Safety Netting**. This screen captures **full** details of the **Advice Provided** along with details of any onward referral.

4.9.15 Should the patient have accessed 999 via a **Care Line** service, it is important that they are notified of the outcome so that they can ensure that the service they provide is continued or temporarily halted as required.

4.9.16 No copy of the ePCR should be routinely provided, however the clinician should ensure that the appropriate **Health Care Advice Leaflet** is provided.

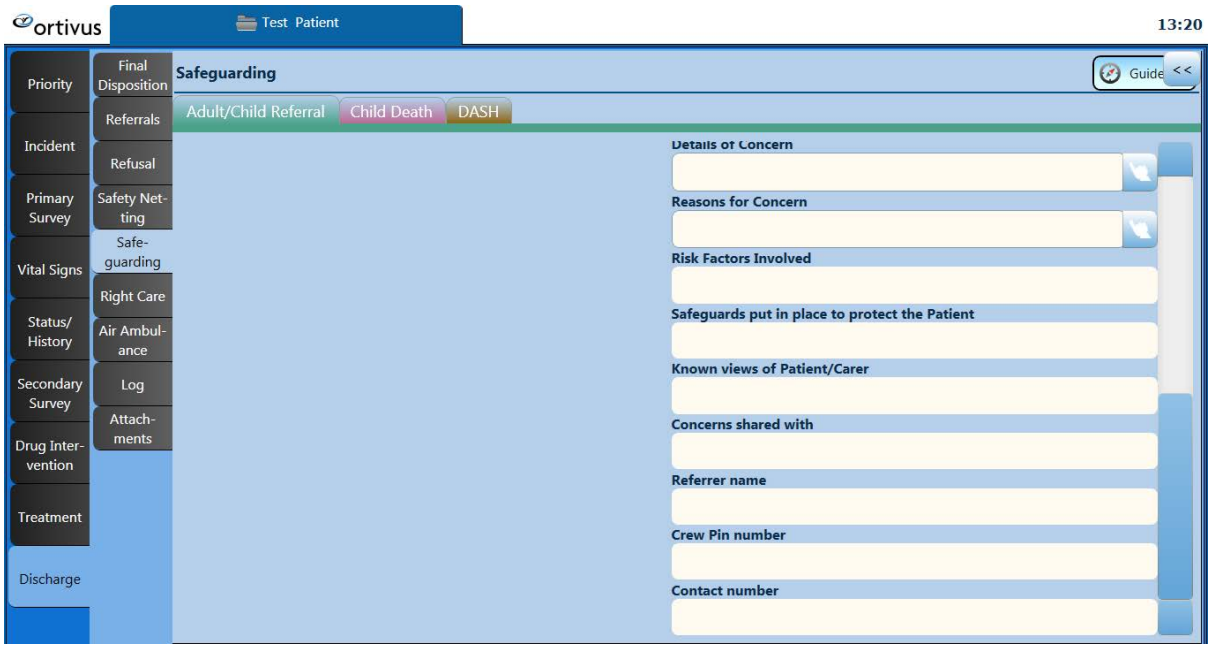


4.9.17 The ePCR greatly enhances the ability of the clinician to undertake **Safeguarding** referrals at the patients address. As with other screens a large number of data fields have been provided in order to try and capture as much information as possible about the circumstances of the referral and importantly about the **soft intelligence** that cannot be sourced at a later date. This includes the atmosphere at the time of the incident, the nature of the environment and any interaction with the Police.

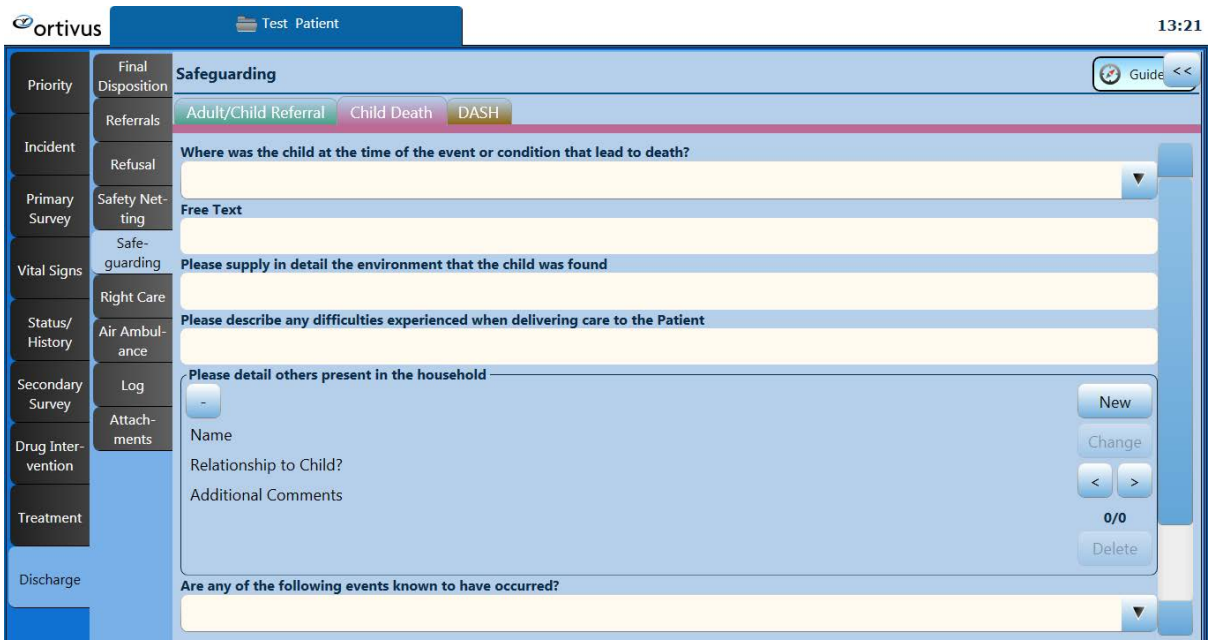


4.9.18 It is important that the clinician review all data fields and provides as much information as possible, either using drop downs, **Yes**, **No** or the **Free Text** fields, which will expand to allow for maximum data capture. It is important that the referring clinician provide their contact details so that further information or clarification can be sourced as soon as possible.

4.9.19 Once completed the **Vulnerable Adult** and **Vulnerable Child** referrals can be accessed and emailed directly to the Trust Safeguarding Team as previously described in the **Referrals** screen

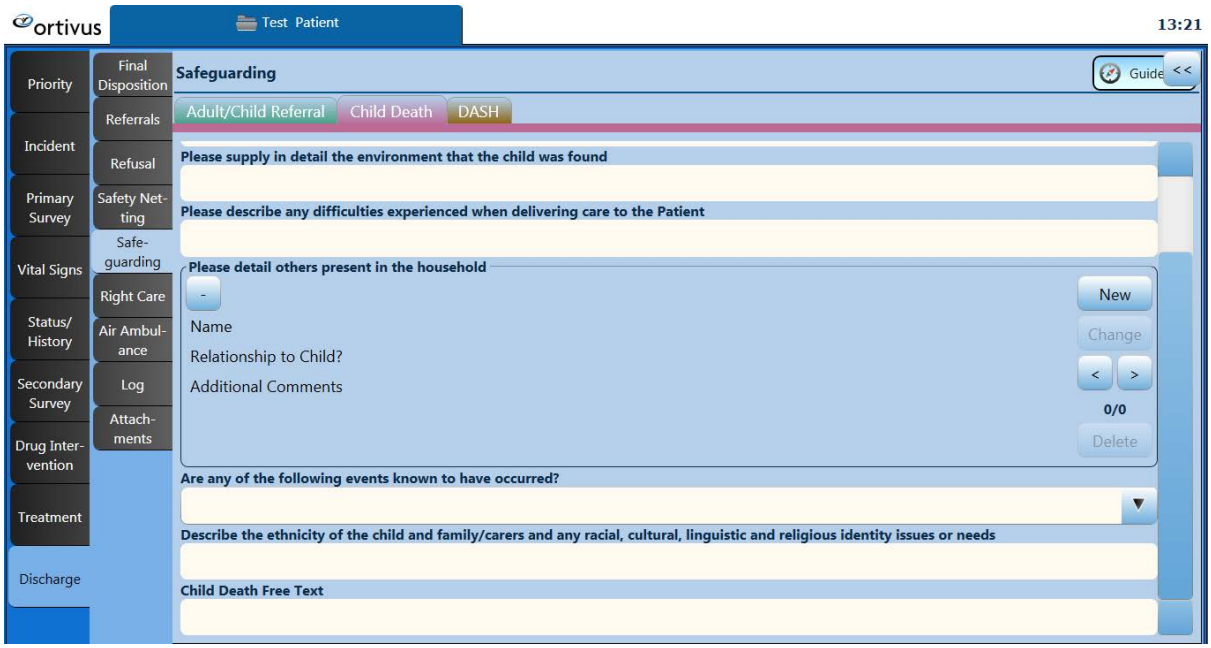


4.9.20 Should the clinician attend and need to document a **Child Death**, the screen below captures data relating to the nature of the death, via the **black drop down arrow**. **Free Text** fields are then provided for any information which may be useful at the time or at a later date for any further review or investigation into the death. It is important that the clinician documents as much detail as possible to ensure that soft intelligence relating to the environment, atmosphere, attitude of those on scene is captured to assist in any future investigation, should that be required.

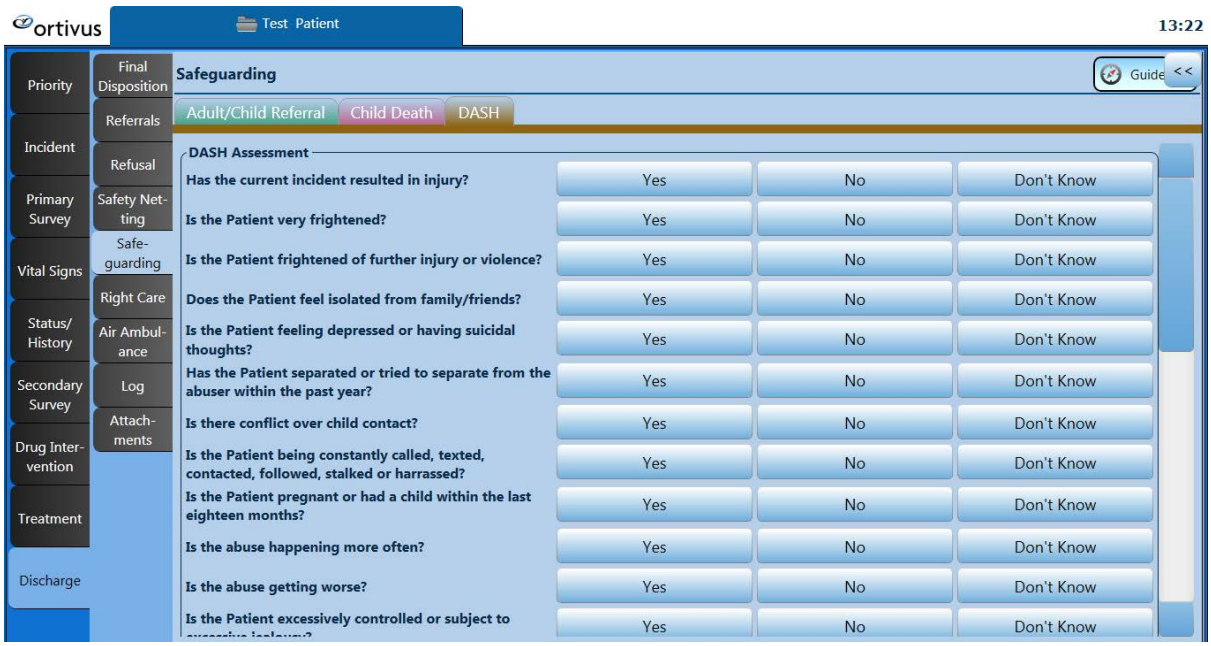


4.9.21 In order to document any and all **Others present in the household** at the time of the ambulance attendance, data fields are provided to capture the name and relationship to the deceased. These fields can be accessed by clicking **New** for each individual present.

4.9.22 Once completed the **Child Death** referrals can be accessed and emailed directly to the Trust Safeguarding Team as previously described in the **Referrals** screen

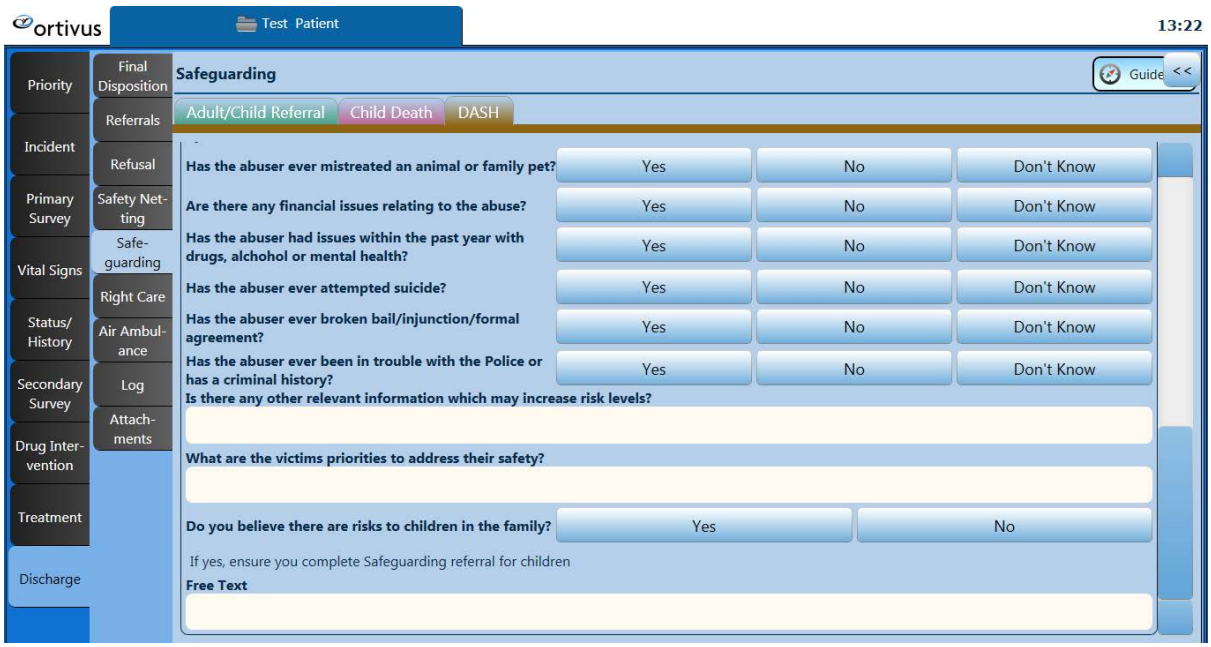


4.9.22 **DASH** (Domestic Abuse, Stalking and Honour Based Violence), supports the clinician in capturing information relating to any domestic abuse or situation arising from stalking or honour based violence. The tool is designed to assist the clinician in capturing information, **BUT**, it should not be read out verbatim but be used as a guide to communication and to assist the clinician in appreciating the information that would be useful.



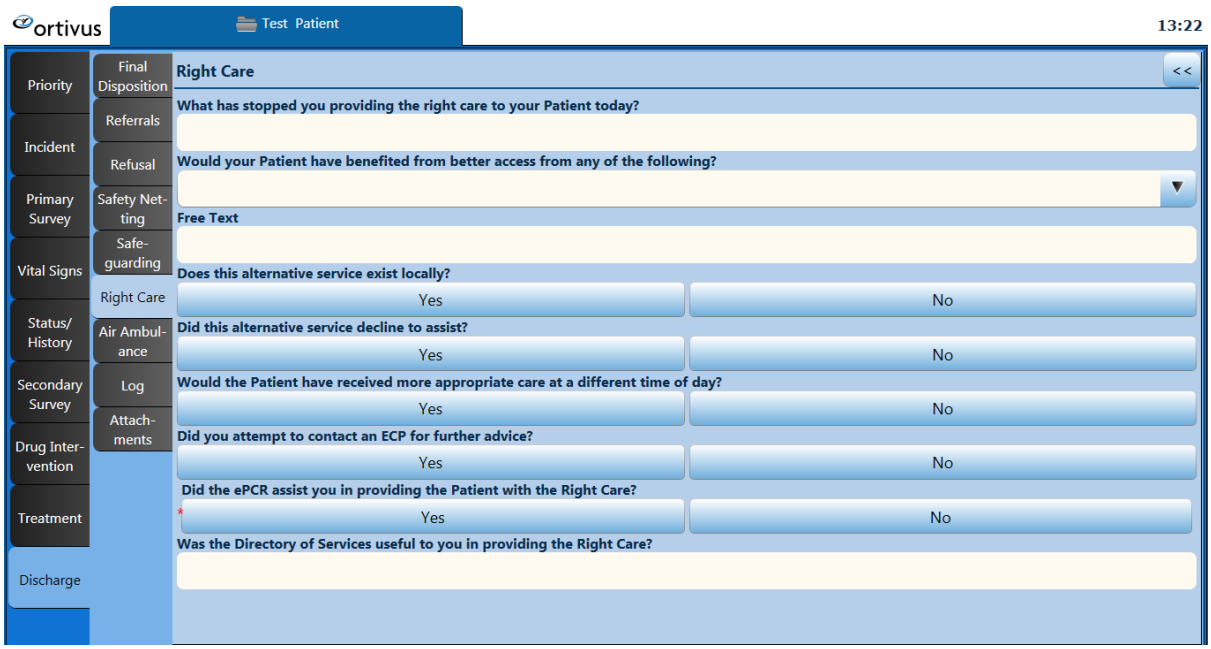
4.9.23 Following the **Yes**, **No**, **Don't Know** questions, additional free test format fields are provided to capture any information relevant to the associated **Risk Level** and the **Victims Priorities**.

4.9.24 Should the victim be an adult, it is also vital that the welfare of any children in the family unit be considered. A **Free Text** field is provided for this purpose, but an additional **Child Referral** may be required.



4.9.25 As the Trust concentrates on providing the **Right Care**, in the **Right Place** and at the **Right Time**, is important that we capture details of any incident where we have been prevented from delivering that care. This may be because the appropriate alternative service does not exist or will not take direct referrals from the ambulance service. This information is collated on a monthly basis and fed back to Clinical Commissioning Groups, so it is vital that this screen is completed every time the **Right Care** is not delivered

4.9.26 As part of the financial commitment provided by central government to the delivery of the ePCR, the Trust is committed to deliver a wider benefit to the NHS. The question **Did the ePCR assist you in providing the patient with the Right Care** has therefore been included as a **mandatory question** within the ePCR configuration. This will assist in evidencing the benefit and providing assurance against the financial outlay.



4.9.27 The **Air Ambulance** screen enables the Air Ambulance to capture data relevant to any mission, this includes details to evidence any clear on scene. A drop down list including Weather, Patient Refusal to fly etc can be accessed by the black drop down arrow.